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ABSTRACT

The Center for Applied Linguistics has compiled these resources on the subjects of war trauma and working with refugees to guide refugee service providers and classroom teachers. The materials include background information about trauma and posttraumatic stress disorder and specific information about problems of refugees and victims of war trauma. The selections in the compilation are designated Appendixes. The United Nations, through its High Commissioner for Refugees and its statement on the rights of the child (Appendix A) has recognized the problems children, especially those from Bosnia, face. Two appendixes (B and C) discuss trauma, posttraumatic stress disorder, and refugees. Two selections focus on children and trauma and consider general developmental issues and coping with grief and the aftermath of disaster. "War Trauma and Refugee Children" contains a description of a film about the effects of torture on children, a discussion of traumatic human rights abuse, and a two-part article on the effects of massive trauma on Cambodian children. "Children of Holocaust Survivors" contains two articles on the symptoms and treatment of child survivors of the Holocaust. A brochure produced to help refugees from the former Yugoslavia cope with trauma is included, and the final section contains six selections on war trauma as an aspect of educating students in the English as a second language classroom. (Contains 19 references.) (SLD)

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ISSUES OF WAR TRAUMA AND WORKING WITH REFUGEES

A Compilation of Resources

Summer 1995

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INTRODUCTION AND ACKNOWLEDGEMENTS

In response to many requests for information about the effects of trauma on refugees, the Center for Applied Linguistics (CAL) has complied resources on the subject of war trauma and working with refugees. The materials include background information about how trauma and posttraumatic stress disorder affect both children and adults as well as specific information about the effects on refugees and implications for ESL teaching.

We hope these resources will guide refugee service providers and classroom teachers in their work with refugees from war-torn countries. We also hope the materials will be useful to program administrators in their search for funding for refugee mental health programs.

We would like to thank the following people for their contributions and assistance: Anne Anderson, the National Coordinator for Psychologists for Social Responsibility, Lorena Bekar, ESL Program Coordinator at the Canadian Centre for Victims of Torture, Irena Sarovic at Progressive Life, Cheryl Tyaska at the National Organization for Victim Assistance, and the Science and Human Rights Program at the American Association for the Advancement of Science.

SUMMARY OF CONTENTS

Recognition of Severe Mental Health Issues for Bosnians

At a European conference organized by the United Nations High Commissioner for Refugees (UNHCR) and the Pharos Foundation for Refugee Health Care, The Netherlands, in collaboration with the WHO/EURO, the final recommendations included recognition of mental health problems and psychosocial needs of refugees, including "specific training dealing with psychosocial needs, [and] reactions to traumatic experiences . . . targeted at . . . teachers . . .." The UN Economic and Social Council (UNESCO) Commission on Human Rights in a statement outlining the rights of the child recognized the particular vulnerability of children to psychological damage from the war in the former Yugoslavia. (See Appendix A)

Trauma, Posttraumatic Stress Disorder and Refugees

"Refugees as Victims of Torture and Trauma" discusses the types of torture experienced by refugees, the long-term effects of the torture, and the stages of healing from trauma. The chapter also challenges the widespread myths that the countries from which refugees come are very different from the United States and always have experienced the kinds of conflicts that have led to today's refugees. (See Appendix B)

"Psychological Sequelae of Traumatic Human Rights Abuses" reviews the common responses to the human rights abuses suffered by many refugees. The psychological diagnoses include posttraumatic stress disorder (PTSD), major depression, maladaptive responses such as the presence of coping mechanisms (e.g., denial, intellectualization, isolation, repression), psychosomatic or psychophysiological disorders and substance abuse. Refugees also have added psychological consequences as a result of being a refugee. (See Appendix C)

Children and Trauma

"Children's Reaction to Trauma" is a general outline of the developmental stages of children and common reactions to trauma experienced by children at different ages. "Some Coping Strategies for Children" provides some basic advice for dealing with traumatized children. Both handouts are produced by the National Organization for Victim Assistance. (See Appendix D)

"Children and Grief" and "Helping Children After a Disaster" are part of the series "Facts for Families from the American Academy of Child and Adolescent Psychiatry." Both provide general information about typical reactions of children and suggestions for how best to deal with children traumatized by death or disaster. (See Appendix E)

War Trauma and Refugee Children

The Canadian Centre for Victims of Torture (CCVT) recently produced "War is not a Game," a 32-minute film exploring the effects of torture on children. The film was produced in cooperation with Frameline Productions and is available through Mulugeta Abai, Executive Director, CCVT, 25 Merton Street, Toronto, Ontario, Canada M4S 1A7 (include a purchase order for $100-Canadian).

"Children and Traumatic Human Rights Abuse" discusses the effects of trauma on children and analyzes the differences between the reactions of children and adults. The chapter also raises the intergenerational consequences of severe trauma and the effects on children of survivors. (See Appendix F)

The two-part article "The Psychiatric Effects of Massive Trauma on Cambodian Children" is a report of a study of Cambodian adolescent refugees. The first part, "The Children," reports the findings from standardized interviews by psychiatrists of 40 Cambodian high school student in the United States. The article discusses the psychiatric diagnosis and major symptom patterns of the students who endured separation from family, forced labor and starvation, witnessed many deaths because of the Pol Pot regime and spent two years living in refugee camps before coming to the U.S. as refugees at the age of 14. The second part, "The Family, the Home, and the School" reports the findings of home interviews with the families of the students and an analysis of school performance and adjustment based on teacher ratings and school records. (See Appendix G)

Children of Holocaust Survivors

"Children of Holocaust Survivors" describes the symptoms exhibited by holocaust survivors and their children, explains the transmission process whereby the children begin to exhibit the same PTSD symptoms as their parents, and offers some suggestions for clinicians working with these children. (See Appendix H)

"An Intergenerational Program Designed for Holocaust Survivors and Their Children" describes a program model used to deal with the sense of isolation and alienation common among Holocaust survivors and their children. The program focuses on developing mutual support for healing and rebuilding a sense of extended family community through inter-generational community assistance. (See Appendix I)

War Trauma Brochure (Serbo-Croatian, English Translation)

"Ratna Trauma i Oporavak" ("War Trauma and Recovery") is a brochure prepared by Irena Sarovic and published by Psychologists for Social Responsibility for people from the former Yugoslavia who have been exposed to ongoing traumatic war experiences and life-threatening situations. The purpose of the brochure is to help them understand common reactions to war trauma and some ways to cope with it. (See Appendix J)

War Trauma in the ESL Classroom

According to Irena Sarovic, a Croatian psychologist, the most important response to a child experiencing trauma is to acknowledge the horrible experience that is causing the trauma and then try to bring the child back to the reality that he/she is safe now. She agreed to be contacted regarding issues of trauma (202-842-2016) and has experience counselling refugees from the former Yugoslavia.

"Educating Educators" analyzes the complexities of teaching English to newly arrived Bosnian refugees within the context of key historical, cultural, social, political and psychological dynamics. The article discusses the issues of genocide, PTSD and the multitude of barriers to English language learning faced by Bosnian refugees in the United States. (See Appendix K)

"Crisis Intervention for the ESL Teacher: Whose Problem Is It?" reviews the mental health problems associated with refugee resettlement, the diverse roles of the ESL teacher, and guidelines for crisis intervention. (See Appendix L)

A final comment in the draft paper "Can TESOL Teachers Address the Mental Health Concerns of the Indochinese Refugees" notes that while TESOL teachers may be in the best position to notice psychological problems experienced by their students, most teachers lack training in the evaluation and diagnosis of mental disorders. The article also warns teachers to exercise caution in dealing with mental health issues in the classroom. (See Appendix M)

"An Overview: ESL for Survivors" explains some mental health issues considered in designing the ESL program at the Canadian Centre for Victims of Torture (CCVT). The article discusses creating a positive classroom atmosphere and limiting class size as ways to raise the confidence of learners. (See Appendix N)

An excerpt from "Primary Prevention and the Promotion of Mental Health in the ESL Classroom" discusses various roles an ESL teacher can assume and the characteristics of an classroom most conducive to the promotion of mental health. Issues of curriculum, materials and teaching approach are also included. (See Appendix O)

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APPENDIX A

EUROPEAN CONSULTATION ON CARE AND REHABILITATION OF VICTIMS OF RAPE, TORTURE AND OTHER SEVERE TRAUMAS OF WAR IN THE REPUBLICS OF EX-YUGOSLAVIA

Utrecht, The Netherlands, 17-19 June 1993

Consultation initiated and organized by UNHCR and the Pharos Foundation for Refugee Health Care, The Netherlands, in collaboration with the WHO/EURO. Co-sponsored by UNHCR and the Government of the Netherlands. With the collaboration of IOM for travel arrangements.

Recommendations

1. It must be recognised that the war in former Yugoslavia is having an impact on the physical and mental health of the entire population, especially that of refugees and displaced persons.

2. Psychosocial assistance to refugees must be recognised as a priority and launched during the emergency phase. Assistance should be targeted towards and at-risk vulnerable groups (1) and priority given to those who have not yet been assisted. This is essential in order to tackle existing mental health problems and to prevent future problems from occurring.

3. Where there is a large presence of refugees, awareness should be raised and special training given in recognition of mental health problems and psychosocial needs. Related information should be offered to refugee community, host population and professionals involved with the organisation of refugee's lives. Specific training dealing with psychosocial needs, reactions to traumatic experience and pathological conditions must be organised and targeted at mental health professionals, PHC professionals (GPs, pediatricians, gynecologists, nurses and others) social workers, teachers, directors of camps, volunteers and all people engaged in organised protection and assistance.

4. Mental health professionals should organise and support outreach workers to identify acute psychosocial needs, conduct sensitive interventions, designed to reduce the stigma associated with violation and to plan a programme of long-term interventions at an individual, family and community levels. These programmes should be realistic, concrete, economical, flexible, unstigmatising, culturally sensitive and non-medicalised whenever possible. Systematic monitoring must be part of the process.

5. Socio-economic self-sufficiency should be encouraged by minimising dependency of refugees on humanitarian assistance and encouraging the reinforcement of existing human resources. Interventions at all levels should be aimed at empowering refugees and displaced persons to play an active role in the management and protection of their mental health.

6. Early family reunion, access to communication with absent family members and support of foster families are of major importance for mental health and should be a priority.

7. Governments, local authorities, non-governmental organisation, international organisations and others should urgently seek ways of normalising the lives of refugees and displaced persons. Protection and assistance are a fundamental part of this.

8. All the above-mentioned parties should work in close cooperation and ensure a rapid exchange of relevant information to the benefit of the refugees.

9. The rights and interests of refugees must be respected and considered before and during any assistance or research project, exposure to mass media and other activities.

10. These recommendations can be systematically applied in other conflicts worldwide.

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(1)These are: children, unaccompanied minors, adolescents, victims of torture and sexual violence, the polytraumatised, ederly, psychiatric patients, ex-detainees, prisoners of war, relatives of missing persons and other priority target groups which may emerge.

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8 March 1994

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COMMISSION ON HUMAN RIGHTS
Fiftieth session
Agenda item 22

RIGHTS OF THE CHILD

Written statement submitted by International Educational Development, Inc., a non-governmental organization on the Roster

The Secretary-General has received the following written statement which is circulated in accordance with Economic and Social Council resolution 1295 (XLIV).

[24 February 1994]

The rights of the child

1. International Educational Development/Humanitarian Law Project brings to the attention of the Commission the situation of children in the armed conflicts in the former Yugoslavia.

2. According to statistics gathered for the period July 1991 to November 1993, in the Republic of Croatia there have been 171 children killed and 712 wounded. Most of the children killed were from eastern Slavonia (51 per cent) and Dalmatia (23 per cent). Forty-three children are severely permanently disabled and another 12 have required amputation of a limb.

3. A total of 4,056 children have been left with only one parent and 44 have lost both parents. An additional 86,000 children are displaced and more than 140,000 are refugees. As a further result of the war, there are more and more children without needed social and medical services.

4. In Bosnia and Herzegovina the situation of children is even worse, especially because there, children must depend almost entirely on humanitarian aid from the international community. Supply of needed aid is constantly endangered because of the day-to-day realities of a war zone.

5. Ninety-one per cent of Bosnian children are exposed to shooting and an estimated 40 per cent have witnessed a death or wounding of another person; 80 per cent of Bosnian children think that they will die within a year due to the wars.

6. The psychological damage from this war will affect these children throughout their lives. Whereas adults can learn to place the horrors and hardships of war in some perspective, children are far more vulnerable and usually unable to develop constructive coping mechanisms.

7. International Educational Development/Humanitarian Law Project appeals to the international community to take adequate measures to assist the children of all wars, and especially those of Croatia and Bosnia and Herzegovina. We urge the international community to ensure that psychologists and psychiatrists receive training in war trauma of children. We urge provision of medical teams to treat the physical wounds of war as soon as possible so that the process of rehabilitation can begin. Finally, we urge the international community to assist the Governments of this region to provide long-term programmes, including adoption in the best interest of the children and enriched education opportunities.

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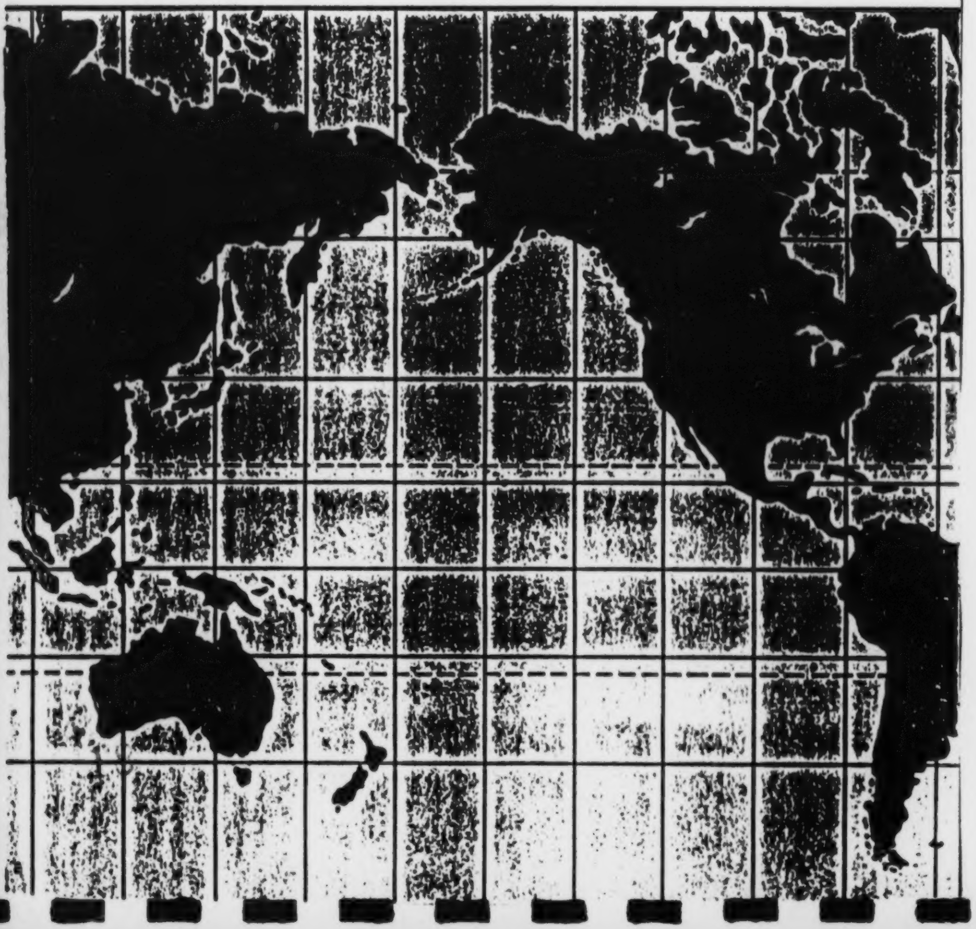
APPENDIX B

Mental Health of Immigrants and Refugees

Proceedings of a Conference
Sponsored by
Hogg Foundation for Mental Health and
World Federation for Mental Health



Refugees as Victims of Torture and Trauma

by Federico Allodi

There are some myths surrounding immigrants and refugees that need to be clarified. (I am using the term "myth" in its pejorative sense: an untruth that, untested, is repeated as history and accepted as truth.) Two myths in particular are quite widespread and not generally challenged.

First is the belief that refugees are people who come from other countries, not countries like ours with governments that are peace loving, fair, and tolerant. History shows otherwise. All countries, including the United States and Canada, at one time or other in their history have produced refugees. The "Empire Loyalists," fearing discrimination and persecution after the War of Independence between the 13 colonies and Great Britain, flew to Canada (100,000 of them) and settled there, as refugees, in 1784. Sitting Bull, the chief of the Sioux nation, with other surviving chiefs, soldiers, and their families, took refuge in Canada after the battle of the Little Big Horn River in 1876. Or more recently, many thousands of young U.S. citizens crossed the border to Canada as draft dodgers during the Vietnam war. Canada sent thousands of citizens of her own land, the Acadians, into forcible exile south of the border in 1755. Still on the Canadian side, after the collapse of the Mackenzie-Papineau and Riel rebellions in Ontario, Quebec, and Manitoba in 1837 and 1885, their leaders flew into exile to various parts of the United States.

The second myth is that countries where refugees come from always did have those kinds of conflicts. Again, the reality is that all countries at one time or another have had problems and internal conflicts similar to those experienced by today's refugees. Think, for instance, of "civilized" Europe during the Nazi regime in Germany, or of the Soviet Union under the Stalin regime, or of the re-education camps in the People's Republic of China, or the massacres in South East Asia against the Sukarno people in 1964 and the devastation unleashed by the Khmer Rouge against the Khmer people in Campuchea, or of the current *polos de desarrollo* (in fact, nothing but militarized villages) in Guatemala and of the 100,000 detained and disappeared people of Latin America in the last two decades.

Any country, under any ideology, can be guilty of committing gross violations of human rights against some of its own citizens, causing them to become refugees. Amnesty International issues annual reports on over 60 countries that commit torture as part of their political and administrative system. It is also worth noting that the refugees we host nowadays in our midst could have been our own grandparents or ourselves under other circumstances. The refugees are no different from us. They share with us the same history of man. They are us.

Much has been written in the last two decades on torture. Lawyers and humanitarians have shown us that torture can occur in a legal and moral universe. Social scientists, physicians, and psychologists have demonstrated that it has a systemic nature. Torture is part of a complex machinery, carefully constructed and well run, which destroys individuals and ultimately the legal and moral fabric of a society. Torture requires a philosophy of rational justification (from the Latin 'ius,' the law, and 'fieri,' to make; that is, to make lawful and legal what is unlawful and illegal). It also requires an agent to implement the philosophy and a body of citizens or victims of this philosophy.

The philosophy or ideology of torture can change to suit the times and political culture in which the abuse appears. In recent times, the atrocities of Stalin were conducted under the assumption of the "supremacy of the State"; the French used the idea of *mission civilizatrice* to justify torture in their Algerian war (Maran, 1989); the military dictatorships of the Southern cone of Latin America used the concept of "national security" (Comblin, 1979), and in the current conflict of the military-dominated governments of Central America the prevalent ideology or justification is "counter insurgency."

The agents implementing this plan constitute a whole system of special police, military intelligence, death squads, and specialists in interrogation and torture, who are selected, trained, and rewarded according to basic and simple principles. The transformation of a human being, a normal citizen–even a neighbor or a friend–into an agent of torture requires the inhibition of his own human nature, so he can regard and act upon his own brother or sister as non-human and as an enemy. An evil act, thus, is transformed into a duty or even a noble action. The state will reward such deeds in many ways, material, social, and psychological. One of them is to grant impunity for such actions and crimes. This reward, amnesty for crimes committed, will gain importance as the kingdoms of terror and torture crumble and the times of re-institution of law and reckoning approach.

The agents use a multiplicity of methods, all of them designed to inflict pain and suffering for the purpose of punishing or coercing the victim to submit to the will of the agent and his regime. Techniques vary from coarse punching, beating, and deprivation of the most basic physical and psychological needs to the refined use of chemicals, electricity, and psychological techniques that confuse and destroy the physical and psychological integrity of the person, as noted in Table 1.

The effect of these techniques on individual victims has been well documented in the medical literature and human rights publications of the last 15 years. Most common symptoms are of a psychological nature–acute anxiety, depression, difficulties with attention and concentration, insomnia, nightmares, jumpiness and suspiciousness–all of

Table 1
Frequency of Reported Methods of Torture (n=41)*

Method	n	Percent
Deprivation		
Food deprivation	12	29
Water deprivation	15	37
Food and water deprivation	16	39
Sensory deprivation	12	29
Overstimulation		
Bright lights, etc.	12	29
Physical torture		
Beating	40	98
Slapping, kicking, punching	40	98
Striking with rifle butt	32	78
Striking with heavy whip, baton, or torch	25	61
Burns from cigarette, chemicals, hot water, or electricity	5	12
Electric shock	27	66
Suspension, hanging by fingers	12	29
Cold water, showers, submersion	15	37
Other physical torture (nail removal, asphyxiation, etc.)	12	29
Rape	6	15
Psychological torture		
Verbal abuse	32	78
False accusations	35	85
Threats of death, execution	31	76
Threats against self, further torture	23	56
Threats against family and friends	13	32
Sham executions	12	29
Other sexual molestation or torture	14	34
Other psychological torture (degradation, excrement in food, etc.)	12	29

*Adapted from Table 1 in Allodi, F. & Cowgill, G. (1982). Ethical and psychiatric aspects of torture: A Canadian study. *Canadian Journal of Psychiatry, 27* (2), 98-112.

which may be present even years after the original trauma, as noted in Table 2.

Specific and refined criteria for the diagnosis of the clinical condition that often followed those traumas and stresses, as in the case of torture, are spelled out in the American Psychiatric Association's Diagnostic Statistical Manual, Third Edition (DSM-III-R) first published in 1980. Named Post-Traumatic Stress Disorder (PTSD), this condition was not new; in both the First and the Second World Wars, descriptions of traumatised soldiers and civilians were reported under the names of shell shock, disorderly actions of the heart, combat exhaustion, and gross stress reaction. PTSD is understood as a cluster of symptoms that generally follows massive or unusually severe stresses, such as concentration camp experience, being a victim of rape, or being involved in massacres or hostage-taking episodes. These man-made experiences should be distinguished from the more common stresses that people may expect to encounter at least once in their lifetime, such as divorce or marital separation, death of a dear person or relative, minor motor vehicle accidents, financial reverses, and migration to another country. The introduction of this concept of PTSD into the study of victims of torture and other human rights violations has permitted more complete clinical descriptions, a more accurate diagnosis, and the possibilities of comparing across national borders reports on various groups of victims. Eventually, the follow up of victims and the study of the outcome of various treatment modalities will be more accurate, given this list of standard criteria.

Table 2
Long-term Effects of Torture (n=41)*

Effect	n	Percent
Physical		
Scars, burns	21	51
Fractures	8	20
Deafness, blurred vision	5	12
Weight loss	10	24
Psychosomatic		
Pains, headaches	22	54
Nervousness	33	80
Nightmares, night panic	14	34
Insomnia	28	68
Tremors, weakness, dizziness, fainting, diarrhea, sweating	26	63
Affective		
Depression	29	71
Anxiety	36	88
Fears, phobias	12	29
Behavioral		
Withdrawal, irritability, aggressiveness, impulsivity	13	32
Sexual dysfunction, severe	5	12
Suicide attempt	4	10
Intellectual and mental		
Confusion, disorientation	5	12
Memory loss	12	29
Loss of concentration	13	32

*Adapted from Table 2 in Allodi, F. & Cowgill, G. (1982). Ethical and psychiatric aspects of torture: A Canadian study. *Canadian Journal of Psychiatry, 27* (2), 98-112.

Follow up studies permit the distinction between short- and long-term outcome of the torture experience. Acute symptoms tend to subside within a few months once the victim is away and safe from the traumatic situation. Even so, a significant level of distress may remain for years after the trauma. A community survey in Toronto, using standardized measures of psychological distress, showed significant differences between refugees who had suffered torture and persecution in their country of origin and immigrants from the same regions of the world who were living in Canada without that traumatic experience (Allodi & Rojas, 1985). It was also discovered that their inner state of psychological distress did not seem to interfere significantly with their major social and family functions.

Children of victims living in exile, on the other hand, seem to enjoy good mental health. Such was the case of Latin American children living in Toronto, Southeast Asians in the United States or Australia, and Soviet children in the United States (Allodi, 1989).

Women as torture victims have been studied in South Africa, in Europe, and in Canada (Foster & Sandler, 1987; Allodi & Stiasny, 1990). The conclusions of these studies appear to be that women are subject to torture by repressive regimes, the consequences of which are very much the same as for victims of rape in civilian crime. Sexual anxiety and avoidance may last for years after the initial trauma.

Treatment of torture victims is aimed at alleviating their psychological symptoms and conflicts, the main consequences of the trauma. Psychotherapy and counseling, both on an individual and group basis, have been the primary approaches. However, most professionals or organizations dedicated to the care of victims of torture have emphasized psychological treatment or counseling within a network of integrated services, including health, legal, and social services.

There are a number of centers in Europe, North America, Australia, the Phillipines, South Africa, and Latin America which provide integrated community-oriented services for torture victims (Reid & Strong, 1986). The center in Toronto, consolidated in 1983, runs programs on intake and assessment, crisis intervention, group counseling, medical and psychiatric network, volunteer support, English as a Second Language classes, support to international projects, public information and community consultation, referral to legal and other community agencies, and job readiness training. It has a community Board of Directors, is financially supported by government, private, and international funds, and operates as a partnership between the community, including the refugee sector, the University of Toronto, the corporate world, and the government. Every year it serves between 300 and 500 new victims and their families from over 40 different countries. The majority of newcomers are from countries reported to be in a state of turmoil and having violated human rights that year. On a first intake interview, between 30 to 50 percent of them declare to have needs of a psychological or mental health nature (Allodi & Simalchik, in press).

Once the victim is in a safe place and away from the source of trauma, normal reparative processes begin to develop. In most cases the victim can be helped considerably by contacts with the natural support network that most people enjoy, such as family, friends, religious leaders, and community groups, even though the experiences of trauma may not be discussed with them. Professional counseling can speed up and influence favorably the outcome of the trauma.

A number of issues and basic concepts have been mentioned in work with torture victims. Commonly mentioned are trust within the patient-therapist relationship, grief reaction and the mourning of the losses suffered as a result of the trauma, survivor's guilt, and engagement in solidarity groups and activities. The counselor should be aware that the victim will have to go at his or her own pace through the process of healing.

Three dynamic stages have been outlined in the process of healing from trauma: (1) denial, (2) acceptance, and (3) integration. At the stage of denial, both the client and the counselor avoid, minimize, or deny the importance of the traumatic experience. Denial is indeed the great enemy of counseling. Traumatic experiences are difficult to discuss and painful to remember. Both patient and therapist want to get on with everyday life, work on the present, and bury the past. There is no conspiracy in this; most commonly it is a simple denial as the most available defense mechanism to avoid pain.

The second stage of healing involves acceptance of the traumatic experience. Acceptance is facilitated by a relationship of trust and empathy with a therapist. Empathy must transcend political and ideological barriers, requiring on the part of the therapist a great deal of alertness for negative or positive counter-transference.

The final stage deals with the integration of the experience of trauma into a new concept of the self and of society and consequent actions. It often requires years of therapy and support. In successful cases, the survivors engage into reparatory work within a particular social context, often called "survivor's mission."

These concepts or stages have been applied not only to individual cases, but they have been proposed to explain reactions of whole communities and nations. Fogelman has applied them to the survivors of the Jewish Holocaust in Israel and similar interpretations have been proposed for Vietnam veterans and for the families of the detained/disappeared persons in Latin America (Allodi & Rousseau, 1989; Fogelman, 1988).

Within a large national context, torture represents a breakdown in the relationship between the state and its citizens; their covenant has been broken. In legal terms, this covenant is addressed by the Universal Declaration of Human Rights and other national and international constitutional rights agreements. This rupture between citizen and the state must be repaired, if the nation is going to be made whole again. The concept and the practice of compensation, which has been recommended and carried out within the context of the Jewish Holocaust and more recently in Latin America, is not only a legal requirement, but also a psychological need if the victims are to feel whole and safe again and to achieve some restitution, albeit more symbolic than material, for the loss of family, community, personal health, and dignity that they suffered.

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APPENDIX C

restlessness, irritability, and insomnia. British troops who were captured by the Japanese and exhibited severe malnutrition and vitamin deficiencies, suffered from fatigue, anorexia, gastrointestinal and cardiovascular symptoms, paresthesia of the feet and legs, and optic atrophy.

51. Oboler, Steven, (1987) American Prisoners of War: An Overview, in Williams, Tom, Editor, *Post-Traumatic Stress Disorders: A Handbook for Clinicians*, Cincinnati: *Disabled American Veterans*, pp. 131-143. This examination program has operated nationwide at all 172 Veterans Administration medical centers since 1983.
52. *Id.*
53. Segal, *et al.*, *supra*, n. 8.
54. *Id.*

2

3. Psychological Sequelae of Traumatic Human Rights Abuses

Traumatic human rights abuses — whether physical or psychological — inevitably leave psychological scars. Victims of such abuse lose their psychologically protective sense of invulnerability as they are rendered helpless and dependent on those who deliberately seek to harm or destroy them. While each survivor reacts differently to his or her experience, the human brain is capable of manifesting only a limited number of psychological responses to a particular type of stimuli. Thus, the psychological sequelae most survivors experience fall, to a greater or lesser extent, within an identifiable range of responses.

Common responses to abuses include recurrent reminders of the trauma while awake or asleep in nightmares, generalized loss of trust in others, hypervigilance, difficulty concentrating, irritability, and depression. Many survivors satisfy the clinical criteria for the psychiatric diagnoses of post-traumatic stress disorder or major depression, which incorporate many of these sequelae. Others experience only some of the elements of these diagnoses. In addition, it is common for survivors to exhibit a variety of other psychological responses to their trauma including substance abuse to mask psychological sequelae, maladaptive attempts at coping, and psychosomatic complaints. These sequelae may be compounded by preexisting psychological problems or problems resulting from the fact that the survivor is a refugee or immigrant who is adjusting to life in a new land. In addition, there is mounting evidence that trauma can cause biological changes in the brain that affect a survivor's psychological responses.

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It is impossible to predict the natural history of stress response in any particular person. But from the few longitudinal studies and the many case reports, it is now known that psychological sequelae may be lifelong and may occur at any time following the trauma — even as long as 30 years later.[1] Studies of concentration camp survivors confirm that post-traumatic sequelae can last for decades. Of 226 Norwegian concentration camp survivors, 99 percent still had psychiatric disturbances 20 or more years after their return to normal life; 87 percent had poor memory and inability to concentrate; 85 percent were nervous and irritable; 60 percent had sleep disturbances; and 52 percent had nightmares.[2]

Not all survivors develop symptoms immediately. While post-traumatic sequelae most commonly occur within a few years after trauma, the latency period may be many years or even decades.[3] The onset may be delayed until well-established defense mechanisms finally become overwhelmed, the stress of flight or relocation diminishes, other psychic associations are made, or other losses become too great.[4]

PSYCHIATRIC DIAGNOSES

Post-traumatic Stress Disorder

As a psychiatric diagnosis, post-traumatic stress disorder (PTSD) is relatively new and is still controversial.[5] It was created in 1980 by the American Psychiatric Association to describe the range of sequelae experienced by survivors of severe trauma.[6] This diagnosis was subsequently refined when the American Psychiatric Association revised its Diagnostic and Statistical Manual of Mental Disorders (3rd edition) (DSM III) in 1987.[7] There is no question, however, that the symptoms of the disorder typify survivors of traumatic human rights abuses as well as other types of human-induced stress.[8]

Indeed, evidence of the validity of the PTSD diagnosis is growing.[9] Barbara Chester, former director of psychological services at the Center for Victims of Torture in Minneapolis, reported that 70 percent of the 38 patients at the center who received complete psychological and psychiatric assessments during the center's first year of operation were diagnosed as having PTSD.[10] In the Amnesty International U.S.A. study of survivors of torture 38 percent fulfilled all the criteria for the PTSD diagnosis.[11] Of the survivors with whom the authors have worked since that study was completed, all but one fulfilled all the criteria for that diagnosis. Richard Mollica, M.D., and James Lavelle, staff members of the Indochinese Psychiatry Clinic in Boston, recently undertook a six-month outcome study of 52 Indochinese patients and found that half of these met the DSM III diagnostic criteria for PTSD.[12] Researchers in Portland similarly diagnosed PTSD in 13 Cambodian refugees who had survived two to four years in concentration camps. These latter two studies confirm that the diagnosis has cross-cultural applicability.[13] The diagnostic criteria for PTSD are set forth in Table 1.

Certain criteria of PTSD appear to occur with greater frequency among survivors of traumatic human rights abuses.[14] All have experienced Criterion A, "an event that is outside the range of normal human experience and that would be markedly distressing to almost anyone." The description of the types of events that satisfy this definition — "serious threat to one's life or physical integrity; serious threat or harm to one's children, spouse, or other close relatives and friends; sudden

TABLE 1 DIAGNOSTIC CRITERIA FOR POST-TRAUMATIC STRESS DISORDER

A The person has experienced an event that is outside the range of usual human experience and that would be markedly distressing to almost anyone; e.g., serious threat to one's life or physical integrity; serious threat or harm to one's children, spouse, or other close relatives and friends; sudden destruction of one's home or community; or seeing another person who has recently been, or is being, seriously injured or killed as the result of an accident or physical violence.

B The traumatic event is persistently reexperienced in at least one of the following ways:

(1) recurrent and intrusive distressing recollections of the event (in young children, repetitive play in which themes or aspects of the trauma are expressed)
(2) recurrent distressing dreams of the event
(3) sudden acting or feeling as if the traumatic event were recurring (includes a sense of reliving the experience, illusions, hallucinations, and dissociative [flashback] episodes, even those that occur upon awakening or when intoxicated)
(4) intense psychological distress at exposure to events that symbolize or resemble an aspect of the traumatic event, including anniversaries of the trauma

C Persistent avoidance of stimuli associated with the trauma or numbing of general responsiveness (not present before the trauma), as indicated by at least three of the following:

(1) efforts to avoid thoughts or feelings associated with the trauma
(2) efforts to avoid activities or situations that arouse recollections of the trauma
(3) inability to recall an important aspect of the trauma (psychogenic amnesia)
(4) markedly diminished interest in significant activities (in young children, loss of recently acquired developmental skills such as toilet training or language skills)
(5) feeling of detachment or estrangement from others
(6) restricted range of affect; e.g., unable to have loving feelings
(7) sense of a foreshortened future; e.g., does not expect to have a career, marriage, children, or a long life

D Persistent symptoms of increased arousal (not present before the trauma), as indicated by at least two of the following:

(1) difficulty falling or staying asleep
(2) irritability or outbursts of anger
(3) difficulty concentrating
(4) hypervigilance
(5) exaggerated startle response
(6) physiologic reactivity upon exposure to events that symbolize or resemble an aspect of the traumatic event (e.g., a woman who was raped in an elevator breaks out in a sweat when entering any elevator)

E Duration of the disturbance (symptoms in B, C, and D) of at least one month

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destruction of one's home or community; or seeing another person who has recently been, or is being, seriously injured or killed as the result of an accident or physical violence" — seems to have been written with survivors of traumatic human rights abuses in mind. Furthermore, DSM-III-R recognizes that traumatic human rights abuses are more likely to produce the disorder than stressors such as natural disasters or car accidents, and that "the disorder is likely to be more severe and longer lasting when the stressor is of human design."[15]

Criterion B, persistent reexperiencing of the event, occurs most frequently in the form of recurrent and intrusive distressing recollections of the event, recurrent distressing dreams of the event, and intense psychological distress at exposure to events that symbolize or resemble an aspect of the traumatic event. As the following example illustrates, these forms are often intertwined. H.H., a male Ethiopian high school student, was arrested at school along with several of his classmates. They were detained together in squalid conditions for a period of three months during which time they were repeatedly tortured. Although all were released, several were apprehended a second time and killed. Since his release, H.H. has had daily nightmares and on occasion has awakened family members with his screams. Whenever he hears Ethiopian music, he recalls his torture and imprisonment. This causes him to cry and feel frightened. He says he prefers to make friends with Americans rather than Ethiopians because the physical features of Ethiopians remind him of his friends and his detention. He also reports becoming symptomatic whenever he sees groups of high school students. During his physical examination he became anxious and fearful at the sight of a reflex hammer. He said it reminded him of the large black rubber mallet used to beat him during torture sessions.

Young children survivors engage in repetitive play in which themes or aspects of their trauma are reexperienced. William Arroyo, M.D., described the play behavior of a five-year-old Salvadoran boy who regularly witnessed aerial bombings of residences, military raids on nearby homes, and local streets riddled with corpses: "He repeatedly played with the available toy soldiers, positioning the military forces on one side and the guerrillas on the other and then knocking them down with one quick handstroke, stating that they all died because they were all bad."[16] It is also common for children to depict their trauma in drawings or artwork.

Survivors the authors have examined have not reported dissociative or "flashback" episodes, which commonly are reported by those who work with Vietnam veterans.[17] But Dr. Arroyo, describing the case of a 17-year-old, politically active Salvadoran girl who was incarcerated for two days and raped by her jailors, reports that she suffered dissociative-like states. On two occasions, a relative observed that the girl "frightfully stared and screamed for approximately two minutes. She was described as being completely indistractible during these states."[18]

Criterion C, persistent avoidance of stimuli associated with the traumatic event and diminished responsiveness to the external world, are common in survivors of traumatic human rights abuses, though not all manifestations of this response occur with equal frequency. The most common avoidance behaviors are efforts to avoid activities or situations that arouse recollections of the trauma and efforts to avoid thoughts or feelings

associated with the trauma. Avoidance can last for decades. The authors have spoken with Armenian genocide and Nazi concentration camp survivors who only recently recounted their stories for the first time. They probably would never have done so had they not been convinced that their testimony was necessary to preserve the historical record. Avoidance may also explain why several survivors with whom the authors have worked, who were politically active in their countries, avoided involvement in political or solidarity activities in the United States, although this behavior may also be accounted for by diminished interest in significant activities.

Psychogenic amnesia appears to be less common in survivors of traumatic human rights abuses than among survivors of other types of traumatic stress. On the other hand, because rarely are there witnesses who can elaborate on a survivor's trauma story, amnesia may be more common than it appears. It was observed in the case of a Salvadoran survivor who suffered a psychotic break and was hospitalized. During his hospitalization he was unable to recall who he was or what had happened to him in the past. After he was stabilized, he was placed in a halfway house for further treatment and recuperation. He then began to recall elements of his past experience including his detention, torture, release, period of hiding, and subsequent life in the United States. The amnesia may have given him time to reintegrate his horrific experiences into his life.

Feelings of detachment or estrangement from others and loss of ability to have loving feelings commonly occur among survivors of traumatic human rights abuses. In survivors of torture, this appears to be related to a generalized loss of trust in others caused by the experience of being rendered helpless, humiliated, and brutalized by another human being. These sequelae are among the most common exhibited by survivors and interfere with the development of new relationships.

Marked diminished interest in significant activities also occurs in survivors of traumatic human rights abuses, though among survivors living in the United States it is sometimes unclear whether this is caused by the traumatic experience, is an element of coexisting depression, or is the result of an inability to pursue former interests because of physical, social, cultural, or linguistic barriers. H.H., the young Ethiopian man described above, was an avid amateur soccer player before leaving his country; in the United States he never plays. His loss of interest probably is attributable to PTSD.

The complex mechanisms that contribute to diminished interest in previously significant activities are illustrated in the case of K.M., a former Czech political prisoner who was active in the human rights movement before being forced to leave his country. In the United States he displays no interest in politics. When he first arrived, his English was poor and he had difficulty adapting to his new environment. Although he had been a professional in Czechoslovakia, the only work he could find was as a blue-collar worker. The realization that he might never again see his chronically ill father, who also was politically active and for that reason was denied a passport, weighed heavily upon him. Shortly after arriving in the United States, K.M. became severely depressed and developed an ulcer. While both problems are now under control, he continues to shun politics but has found satisfaction in artistic pursuits.

Few of the survivors with whom the authors have worked have expressed a sense of a foreshortened future, though this question was rarely explored. Most are refugees who are adjusting, with varying degrees of success, to life in the United States. Several were forced to give up professional careers because they could not satisfy state licensing requirements and thus have had to accept lower career expectations. Older persons have talked of not living much longer, though it is hard to tell whether this is the result of their traumatic experience or their coming to terms with the process of aging.

The sense of a foreshortened future was described in detail by Lenore Terr, who documented the sequelae in children from Chowchilla, California, who were kidnapped and temporarily buried alive.[19] This response may be more common among children than adults.[20] Adults are much more likely to have a life framework that includes such self-defining elements as a career, spouse, children, a home, and material and financial means. They also have greater self-awareness that comes with maturity. Without years of life experience to bolster them, traumatized children may be less likely to be able to put their traumatic experience into context or to believe that they can successfully achieve ordinary life goals. Without these goals their futures may appear short and bleak.

H.H., the Ethopian described above, was high school age when his trauma occurred. Before his torture he was a good student and his ambition was to become a physician. After his torture he lost sight of this goal and now, more than 10 years after his traumatic experience, works in a menial job.[21]

Common Criterion D symptoms are increased arousal, difficulty falling or staying asleep, difficulty concentrating, and physiological reactivity upon exposure to events that symbolize or resemble an aspect of the traumatic event. Irritability and outbursts of anger also are common but appear to occur with less intensity than they occur in other traumatized groups such as hospitalized Vietnam veterans.

Sleep disturbances are among the most common complaints of torture survivors.[22] Survivors complain of nightmares, insufficient sleep, and daytime fatigue. Researchers have found frequent awakening from REM sleep, decreased REM sleep, absent stage-4 sleep, short total sleep time, and low sleep efficiency among these survivors.[23]

Hypervigilance appears to be universal among survivors of traumatic human rights abuses but is of a different character from that reported in studies of Vietnam veterans. The latter tend to be jumpy and always looking over their shoulders for the enemy. The nature of the hypervigilance experienced by survivors of traumatic human rights abuses tends to be related to their specific trauma experiences. Thus, survivors who experienced unanticipated physical assault while blindfolded are likely to be hypervigilant for auditory clues of impending attack.

In addition, survivors living in exile often exhibit fearful or even paranoid behavior related to the political circumstances in their countries. Persons from countries where traumatic human rights abuses still occur often are guarded about doing or saying anything that could have repercussions for family or friends living there. Many are afraid to tell their stories to United States government officials for fear the authorities in their countries will be informed. Others act as though new acquaintances are spies and are circumspect about interacting with others. Even survivors from countries that have experienced a change in government tend to worry that the new government will topple and be replaced with a repressive regime. While survivors' fears are often valid, in some cases part or all are paranoid ideation caused by past trauma.

Major Depression

Major depression is another frequent, and commonly missed, diagnosis exhibited by survivors.[24] For example, nearly all of a representative sample of Hmong refugees living in Minnesota in 1977 were diagnosed as having major depression.[25] Other survivors have features of depression without satisfying all the criteria for a major depressive episode. Depression commonly is observed in patients who also fulfill the diagnostic criteria for PTSD. The diagnostic criteria for major depression are set forth in Table 2.

Depression may occur spontaneously; may be related to the loss of friends, relatives, employment, home, money, social status, self-esteem, self-worth, or dreams of how the future may have been; or may be provoked by causes such as inability to adapt to a new language or new culture.

For example, C.M., a printer from a Central American country, was arrested at his place of business. During his detention he was kept in cold, inhospitable surroundings, tortured with electric shocks, and forced to dig a ditch that he believed would be his grave. Now a refugee living in the United States, he suffers from major depression characterized by depressed mood, loss of interest in many activities, loss of a significant amount of weight (20 pounds in a six-month period), insomnia, and fatigue. He also experiences frequent bouts of anxiety, socializes far less than in the past, and feels that he has less zest for life.

Suicide attempts are one of the most serious manifestations of major depression. Provoked by depression, despair, or feelings of isolation or futility, the suicide may be attempted with one's own hand or by provoking someone else. R.R., an Iranian survivor, twice attempted suicide by overdosing on medications surreptitiously collected, but was thwarted on both occasions by his wife. J.R., a Salvadoran man, had a specific plan for committing suicide by jumping off a bridge. He decided against it at the last minute after positioning himself for the jump. He also had several confrontations with the police "in the hope that they would kill me."

Suicides or suicide attempts may be precipitated by stressful events that occur after trauma. For example, M.P., an African man who was to appear in court as part of the process of seeking political asylum in Canada, committed suicide the night before his final hearing. Counselors who worked with him surmised that he could not bear to relate his story in the adversarial courtroom environment or the possibility of deportation.[26]

Maladaptive Responses

Coping Mechanisms

Everyone has coping mechanisms to deal with stressful events. These mechanisms, which may be helpful or may mask or exacerbate psychological sequelae,

TABLE 2 DIAGNOSTIC CRITERIA FOR MAJOR DEPRESSION

A At least five of the following symptoms have been present during the same two-week period and represent a change from previous functioning; at least one of the symptoms is either (1) depressed mood, or (2) loss of interest or pleasure. (Do not include symptoms that are clearly due to a physical condition, mood-incongruent delusions or hallucinations, incoherence, or marked loosening of associations.)

(1) depressed mood (or can be irritable mood in children and adolescents) most of the day, nearly every day, as indicated either by subjective account or observation by others

(2) markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day (as indicated by subjective account or observation by others of apathy most of the time)

(3) significant weight loss or weight gain when not dieting (e.g., more than 5 percent of body weight in a month) or decrease or increase in appetite nearly every day (in children, consider failure to make expected weight gains)

(4) insomnia or hypersomnia nearly every day

(5) psychomotor agitation or retardation nearly every day (observable by others, not merely subjective feelings of restlessness or being slowed down)

(6) fatigue or loss of energy nearly every day

(7) feelings of worthlessness or excessive or inappropriate guilt (which may be delusional) nearly every day (not merely self-reproach or guilt about being sick)

(8) diminished ability to think or concentrate, or indecisiveness, nearly every day (either by subjective account or as observed by others)

(9) recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide

B (1) It cannot be established that an organic factor initiated and maintained the disturbance and (2) the disturbance is not a normal reaction to the death of a loved one (uncomplicated bereavement)

C At no time during the disturbance have there been delusions or hallucinations for as long as two weeks in the absence of prominent mood symptoms (i.e., before the mood symptoms developed or after they have remitted)

D Not superimposed on schizophrenia, schizophreniform disorder, delusional disorder, or psychotic disorder NOS.

E Has never had a manic episode or an unequivocal hypomanic episode

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may be adapted from one situation to another, and can color a survivor's perception of his or her experience. Common defenses used by survivors to cope include denial, intellectualization, isolation, repression, suppression, dissociation, somatization, and undoing.[27]

Persons working with survivors should look for signs of these coping mechanisms and for their effect on the survivor's management of psychological sequelae. Sequelae may be more or less troubling depending on the person's coping strategy. Many survivors vacillate between periods of intrusive symptoms and recollections and periods of denial. During periods of denial, sequelae are masked and the person appears to be coping fairly well.[28]

Survivors who use denial as a coping mechanism fail to acknowledge the connection between the traumatic event and their post-traumatic reactions to items that remind them of the event, even when the connection is readily apparent to others. R.P., an Iranian man, was afraid to answer his phone, hid in a cupboard whenever someone came to his door, and had other psychological sequelae as a result of his trauma, but was convinced his behavior was normal. At the close of a documentation interview, A.D., a South American surivior with PTSD and depression, sought reassurance that he was normal and requested that his family be informed that there was nothing wrong with him.

Intellectualization, isolation, repression, and suppression are all related coping mechanisms in that they are attempts to isolate affect or feelings from thoughts. Intellectualization is a process in which the survivor engages in excessive abstract thinking to avoid disturbing feelings. For example, two former Chilean military men were arrested following the 1973 coup d'etat in which President Allende was killed. They were detained and tortured by members of the service to which they belonged. They believed that the abuse to them was somehow justified, but that the torture of women prisoners was wrong.

In isolation a survivor is unable to experience thoughts and feelings simultaneously because affect is kept from consciousness.[29] Isolation is common in survivors who are required to describe what occurred to them in court or in some other official context. In giving testimony they characteristically describe the most horrific experiences with little or no affect and therefore do not appear to be credible witnesses.

In repression the survivor is unable to remember disturbing feelings, thoughts, or experiences. Repression is hard to detect, though it becomes evident in situations in which the survivor is reinterviewed after the passage of time. For example, a Chilean survivor who was interviewed a month after his torture descibed his experience in vivid detail, was unable to recall significant elements of his experience when reexamined a year later. Repression may also be detected when more than one witness to the same event is interviewed.

Suppression, a core part of the PTSD diagnosis, is a common coping mechanism among survivors. In suppression the survivor intentionally avoids thoughts or activities that remind him or her of disturbing problems, desires, feelings, or experiences. Some accomplish this by becoming too busy to reflect. Therapists using behavioral modification sometimes teach suppression as a coping technique.

Dissociation is an unconscious defense mechanism in which a group of mental processes is split off from the rest of a person's thinking or accompanying affect, resulting in an independent functioning of this group of processes and thus a loss of the usual interrelationships.[30] Two types of dissociation — depersonalization and frozen fright — are commonly invoked during severe trauma. Dissociation during trauma may be related to dissociative sequelae later.[31]

Depersonalization, in which a person dissociates actual experiences from those that are perceived, is a common defense mechanism during torture. Survivors who have depersonalized their torture may describe their experience in terms such as "They tortured my body, but they did not torture me" or "I imagined that I watched them torturing me while floating above them." These survivors are more likely to use dissociation as a coping mechanism afterward. Depersonalization may also occur during and after sexual abuse.

Frozen fright commonly occurs in situations in which a trauma victim's only perceived hope of survival depends on his or her persecutor. Persons who dissociate in this manner exhibit cooperative behavior during trauma, with motor and cognitive functions working normally, but without the associated affect. They know that if they cry out or react with rage they risk death or selection for further punishment as an example to others.[32] Maladaptive frozen fright may later occur outside the trauma context when triggered by associative cues.

Undoing is another defense mechanism that occurs in survivors, especially those who believed that they should have thought or behaved differently during trauma.[33] By undoing, a survivor symbolically makes amends for or negates previous thoughts, actions, or feelings. For example, O.T., a Central American refugee, witnessed the rape and murder of a neighbor, but remained hidden and did not intervene. While at the time he probably responded out of fear to protect himself, he now perceives that his conduct fell short of his ethical standards and blames himself for the neighbor's death. This man is now working as a social worker in a refugee center.

Psychosomatic or Psychophysiological Disorders

For many survivors it is more acceptable culturally to suffer from physical ailments than from psychological complaints. Others misconstrue their feelings as physical symptoms. Current theory explains psychosomatic illness using a biopsychosocial model; the DSM III and DSM IIIR use the phrase "psychological factors affecting physical conditions" and group psychosomatic illnesses under the rubric "somatoform disorders." Somatoform disorders most relevant to the survivor population are conversion disorders and hypochondriasis.[34]

The essential feature of a conversion disorder is an alteration or loss of physical functioning that suggests a physical disorder, but is in fact an expression of a psychological conflict or need.[35] The symptoms cannot be explained by any physical disorder or known pathophysiologic mechanism. In addition, psychological factors are etiologically related to the symptom, the person is not producing the symptom intentionally, the symptom is not culturally sanctioned, and the symptom is not limited to pain or a disturbance in sexual functioning. A.G., a Chilean man who escaped from his home while his family was being detained but was later captured, complained of intermittent paralysis of both legs, lasting a few minutes. A complete medical and neurological evaluation of this man, who had been beaten on his back, was normal.

Hypochondriasis is the fear or preoccupation with the belief that one has a serious disease. It is based on the interpretation of physical signs or sensations as physical illness and persists despite medical reassurance.[36] Hypochondriasis may gain a foothold if someone believes that because he or she witnessed or was subjected to something, a culturally defined harm will ensue. Suggestions made during trauma that a person's body or brain will be permanently damaged can also lead to hypochondriasis. C.S., a Central American peasant, believed before electric shock torture that his heart would explode under such treatment and he subsequently thought that his heart had been irreversibly damaged. Similarly, S.G. was told during torture that her mind would be altered by the experience. She subsequently had uncontrollable intrusive imagery, which added credence to her abuser's claim and intensified her belief that she had suffered brain damage.

Substance Abuse

Survivors who are trying to control intrusive PTSD symptoms or sleep disturbances may abuse alcohol or drugs.[37] Some may have abused substances before their trauma, but in our experience prior problems are rare.

The DSM-III-R groups 11 classes of abused substances into three main groups: alcohol, sedatives, anxiolytics (substances to decrease anxiety), and hypnotics (sleeping medicines); cocaine, amphetamines, or other sympathomimetics; and hallucinogens, phencyclidine (PCP), or similarly acting arylcyclohexylamines. Survivors most commonly abuse substances in the first group. Alcohol is readily available and the most socially acceptable of the abused substances. For example, H.M. developed a pattern of alcohol abuse. He was a middle-aged, well-educated Iranian survivor of two detentions who had been beaten, threatened with sham executions, and deprived of food and water and had watched a fellow detainee die in his arms following torture. Before his detention he rarely drank alcohol. At the time of his examination several years later he was drinking between one-half and four-fifths of a quart of vodka a night to enable him to sleep and control his intrusions.

Anxiolytic medications such as alprazolam (Xanax) and diazepam (Valium), which are available by prescription, are effective in suppressing PTSD symptoms; survivors with access to these medications may allow themselves to become dependent on them.

Other Psychological Sequelae

Other psychological sequelae occasionally seen in survivors include schizophrenia and brief reactive psychoses, mental retardation, and learning disorders. Schizophrenia occurs statistically more frequently in refugee populations than in nonrefugee populations but occurs in only a small percentage of refugees. More common are brief reactive psychoses. These are psychotic conditions preceded by a stressful event that have a short duration and a good prognosis.[38] Survivors who were malnourished in childhood, starved later in life, or have had high fevers or head injuries are more likely to suffer mental retardation or problems with learning.[39]

Far more common is complicated bereavement. Survivors who have lost friends or family members during flight, under torture, or because they "disappeared" or were murdered have reason to mourn. Mourning is the process by which grief (the feelings precipitated by the loss) is resolved. Grief is expressed as a feeling of numbness and bewilderment followed by suffering and distress. Physical symptoms include weakness, anorexia, weight loss, and problems with concentration, breathing, and sleeping.

Normal grief subsides over time and for the most part is expended in one or two years. Although some people have grief-related symptoms, feelings, and behaviors throughout their lives, most rekindle feelings of well-being and productivity. Self-blame, centering on what was or was not done with respect to the deceased, is often a part of normal grief.

Bereavement may be complicated by multiple deaths as a result of war, death squad activity, or genocide by governments. The Nazi concentration camp survivor literature provides numerous examples of sole survivors of extended families. These persons lack family and community to share their grief and support them through the mourning process.

Bereavement may also be complicated if no reliable word about the death has been received, the deceased's body has not been recovered, or a person has "disappeared" and the govenment has not acknowledged the arrest, detention, or death.[40] Family members may hope that their loved one is in transit, alive in a refugee camp, safely living abroad, or in unacknowledged detention. In these situations individuals or families may be unable to initiate or complete the mourning process.

Major depression may occur in the context of complicated bereavement. When symptoms of depression, such as feelings of worthlessness and psychomotor retardation, occur, the diagnosis of major depression should be considered.[41]

Downward socioeconomic drift is another psychological sequela sometimes seen in survivors. Survivors, when they become refugees, may not be able to continue working in their chosen professions because of licencing requirements, linguistic difficulties, or other refugee-related problems. Those who once thought of themselves as middle or upper class may find that they cannot maintain the same level of income or social status in their adopted country. Families that become separated may find it harder to maintain an adequate standard of living because fewer members are earning income or because more than one household must be supported. The high cost of living in many metropolitan areas where refugees congregate may also force survivors to accept a lower standard of living.

But downward socioeconomic drift may also be a sequela of trauma. Leo Eitinger reported that non-Jewish Norwegian concentration camp survivors had lower working capacity and stability and, despite liberal pension benefits, fared far worse than controls.[42] Several studies have shown that Vietnam war combat veterans also have reduced working capacity and earn less than controls.[43]

Not all survivors have been financially unsuccessful. Certain populations, such as Jewish Holocaust survivors, Cubans, Armenians, Persians, and ethnic Chinese from Vietnam, have done well materially but each of these communities has had a support network in place to help them resettle and start new occupations. The Nazi concentration camp survivor literature indicates that post-traumatic psychopathology contributes to material success. Yael Danieli, a researcher in the Group Project for Holocaust Survivors and Their Children in New York, reported that one of the chief preoccupations of these families was survival and that they would hoard food or money for fear of another Holocaust. Jewish men, who during the Holocaust were unable to provide for their families' survival or protect their loved ones from a terrible fate, made "earning a living" the focus of their post-trauma lives and became compulsive workers.[44] One group of survivors, who Danieli called "Those Who Made It," were particularly "successful":

> *Many survivors in this group were motivated by a wartime fantasy and desire to "make it big," if they were liberated, in order to defeat the Nazis. Some focused on making a big name for themselves, to consciously or unconsciously counteract the namelessness, humiliation, degradation, and shame they had experienced during the Holocaust. Some were motivated by a powerful need to bear witness. Persistently and singlemindedly they sought higher education, social and political status, fame, or wealth. As with other survivor families, they used their money primarily for the benefit of their children rather than for their own enjoyment.*[45]

Other researchers who worked with Holocaust survivors have reported this need to accumulate wealth without any accompanying desire to enjoy it.[46]

Other Conceptualizations of Psychological Sequelae

In addition to the psychiatric diagnoses and descriptions of post-traumatic sequelae discussed above, psychiatrists and psychologists have conceptualized in a variety of other ways the constellations of symptoms survivors exhibit. Two worth noting are learned helplessness and alexithymia.

Learned Helplessness

Learned helplessness is a term borrowed from behavioral psychologists and occurs when subjects perceive that their behavior does not affect their environment. This situation leads survivors to doubt their ability to control their emotions and lives.

Learned helplessness that develops during trauma may later be transferred into the post-traumatic environment. One of the most common, as well as most devastating, types of human rights abuse is denial of control over even the most basic decisions.[47] Faced with real helplessness, some victims feel that they have lost the capacity to take control even when it is within their power to do so. These feelings may be retained after the trauma has ended and may become generalized so that survivors believe they cannot learn new coping strategies, lack the motivation to try, and feel distressed. In essence, they have learned to be helpless.[48]

Alexithymia

Alexithymia is "the inability to be aware of and to tolerate basic feeling states; the constriction of affect, cognition, and action; and a disorder of hedonic regulation."[49] Alexithymia is a psychotherapeutic concept that was developed by P.C. Sifneos to describe multiple psychological disabilities that survivors commonly exhibit.[50] It has been described in post-traumatic populations and in psychosomatic patients.[51] Persons with alexithymia lack the ability to monitor properly their emotions and to select the proper emotion when interacting with the external world. Thus, a person with alexithymia is unaware or less aware of basic feelings and cannot use their emotions as guidelines for action, is unable to tolerate feelings that do occur and cannot recognize these feelings, has a decreased ability to conceive abstract thoughts, and has a decreased ability to feel pleasure.

Added Psychological Consequences of Being a Refugee

Nearly all survivors of traumatic human rights abuse outside their countries are refugees or immigrants. Their trauma stories and the effects their experiences have had on them are inextricably intertwined with the additional stresses of being a refugee or immigrant.

The stresses of immigration may be divided into three parts: premigration stressors, migration stressors, and arrival stressors. Premigration stressors include the traumatic human rights abuses that drove the person to become a refugee coupled with the refugee's pretrauma economic, social, cultural, political, medical, and other circumstances.

Migration stresses depend on the nature of the migration process. For some, the process is orderly: the survivor obtains a visa, travels to, and enters the new country without incident. But for others the process is chaotic and involves great personal risk, such as being subjected to pirates, traveling through combat zones, staying for a prolonged period in a refugee camp, or entering the new country unlawfully. Such experiences are themselves traumatic and complicate post-traumatic sequelae.

Arrival in the new country is usually accompanied by feelings of optimism and exhilaration. A tremendous amount of energy and willingness to adapt, find housing, learn a new language, look for employment, and generally settle in are characteristic. It can take months or years for refugees to face the breaking of psychological and physical bonds with their homelands and become homesick. They have lost familiar social supports, must adjust to a new culture, and may have to learn a new language. They are often subject to a change in economic position, resulting in the need for retraining or acceptance of a less-skilled job. Their social status and the dynamics and hierarchy within their families may change dramatically. For example, women who traditionally stayed inside the home may suddenly find themselves to be the only employed person in the family. Because children adapt and learn new languages more quickly, adults often rely on them to act as go-betweens with the host community. This can cause traditional power relationships within the family to be altered. Tensions may occur if children want freedoms of which their parents do not approve. The sum of the above dilemmas and adjustments is termed "culture shock" and is characterized by the anxiety-provoking need to act while being confronted by unfamiliar social norms and behavioral cues.[52]

Minorities already living in the host country may feel that the refugees are getting more than their share of scarce resources and are thereby depriving them. Survivors may be subjected to outward discrimination, racism, or xenophobia. Those who have experienced past discrimination on the basis of ethnic or racial characteristics may be frightened by discrimination, quotas, or segregation of their own or other ethnic groups.

The tremendous adjustments refugees typically make are not without psychological cost. Worldwide the incidence of psychiatric diagnoses is higher among refugees. This is true for Russians in Norway, eastern Europeans in Canada, Hungarians in England and Canada, Cubans in the United States, Indians moving out of Pakistan, mainland Chinese in Taiwan, and Vietnamese, Cambodians, and Laotians in the United States.[53]

Refugees who dwell on their desire to return to their homeland often have a difficult time adapting to life in the new country, while those who accept that return is not possible seem to acculturate faster. Those who maintain active political ties in their homelands also tend to acculturate more slowly, though among survivors, resumption of political or solidarity work may be therapeutic. A success in one's occupation can be helpful in the process of acculturation but may become one's reason to exist to the exclusion of all else.

Another significant stressor, secondary migration, is experienced by refugees who move from a country of first asylum to a third country. It also occurs when refugees move to a new location in the host country to be closer to family or other members of their national or ethnic group or to enjoy greater participation in cultural affairs. Secondary migration forces the refugee to once again adjust to a new environment; the stressful effects of readjustment may or may not be offset by the potential advantages of the move.

The greater the cultural and social distance between two peoples, the more difficult the acculturation process. For example, a subsistence farmer may have difficulty adjusting to life in a large city. A person who speaks a non-Indo-European language may have more difficulty learning English or getting used to Western social, political, and governmental institutions.

Lastly, people acculturate in different ways and to different degrees. A survivor's acculturation style, whether adaptive or destructive, almost certainly will be intertwined with and affect or be affected by post-traumatic sequelae.

Biological Responses in the Brain to Trauma

Recent research, while inconclusive, indicates that many psychological responses to severe trauma have a biological component. As Walton T. Roth writes:

> *Trauma elicits a variety of cognitive and affective activities, varying from person to person, which can include cognitive coping strategies, unconscious defense mechanisms, depression, anxiety, and even hallucinations and delusions. All these*

activities have both psychological and biological aspects, have both meanings and neurophysiological substrates.[54]

Since 1956, when Hans Selye studied changes in the adrenal cortices of rats subjected to prolonged stress, researchers have been aware that stress can have anatomic and endocrine effects.[55] More recently researchers using animal and human subjects have examined a broader range of neurobiological consequences of trauma. Some studies involve parts of the brain that play an important role in the recollection of events, memory, dreams, and fear (such as the limbic system and the locus coeruleus). Others endeavor to provide a functional explanation for the magnification and persistence of PTSD symptoms through the phenomenon of "kindling," involving electrical activity in the brain. Still others view the biological responses to stress as they are manifested in the immune and endocrine systems, neurochemical and neuroendocrine activity, and biologically active substances or their metabolites in blood and urine.

The locus coeruleus, a part of the hindbrain in humans, is activated by fear-producing stimuli and, in turn, activates other fear centers in the brain. If stimulated, it produces fear and alarm states; monkeys whose locus coerulei are destroyed are fearless. Van der Kolk presents evidence that this part of the brain is involved in the intrusive phenomenon of PTSD.[56]

The locus coeruleus helps regulate sleep and is involved in the production of nightmares. Van der Kolk and colleagues suggest that changes in the locus coeruleus cause changes in other parts of the brain. These changes account for nightmares in which exact visualization of events occurs rather than normal, more dreamlike types of nightmares.[57]

In kindling, repetitive, subthreshold chemical or electrical stimulation of the brain that repeats in an unpredictable sequence causes much greater neurological and behavioral responses than expected.[58] In research animals this sort of stimulation can lead to seizures.[59] The phenomenon of kindling may explain why some survivors suffer psychological or psychophysiological sequelae such as anxiety or rapid heartbeat and sweating when exposed to objects or events that symbolize or resemble an aspect of their trauma.[60]

For example, victims of torture commonly are exposed to an unpredictable series of noxious physical and psychological stimuli that their senses transmit electrochemically to their brains. This electrochemical stimulation may cause the brain to be kindled. After kindling, reactions to future stimuli reminiscent of the torture should be much greater than those experienced during the torture or those expected as a normal result of such stimulation.

The kindling effect has been shown to be of long duration and researchers have hypothesized that an underlying physical change such as an anatomic synaptic reorganization or hypersensitivity may occur.[61] This may explain why survivors of traumatic human rights abuses do not habituate or get used to the stimuli that produced their sequelae. For example, a person who suffered electric shock torture may never be able to look at certain electrical devices without experiencing fear and sweating.[62]

Other Biological Responses to Stress

Research to investigate the differences between stress in which subjects retain control over their environment and stress in which subjects have no control indicates that the psychological and biological effects of the two types of stress differ. Breier and coworkers used 10 human volunteers and exposed them to a loud noise on two occasions.[63] Both times the subjects were told they could stop the noise, though in reality this was only true in one trial. The amount of noise to which the volunteers were exposed was equal in both trials. The researchers then measured hypothalamic pituitary function, electrodermal activity, and selfratings of helplessness, anxiety, and depression. In the controlled stress situation the subjects reported greater anxiety, helplessness, and depression, and showed increased neurochemical and neuroendocrine activity.[64] These neurochemical and neuroendocrine effects lasted well beyond the cessation of the stimulus and far longer than the expected release period of neurochemicals and hormones during stress.[65] This research suggests that the amount of control a person possesses during trauma can affect the severity of sequelae.

Research shows that objective physiologic measurements are indicators of post-traumatic sequelae. By studying blood pressure, pulse, and skin resistance in response to sound, researchers studying veterans distinguished PTSD patients from controls.[66] In addition, urine and blood measurements of norepinephrine:cortisol ratios are fairly reliable in distinguishing persons suffering from PTSD from those suffering from other psychological disorders.[67]

Immunologic changes have been reported in humans exposed to stress. Joseph Calabrese and coworkers note that immunologic abnormalities seen in depression are very similar to those in bereaved and chronically stressed people.[68] According to these researchers, the hypothalamic-pituitary axis is the mechanism through which stress influences the immune system. Neuroendocrine cells in the various lymphoid (immune system) organs suggest a link between the neuroendocrine and the immune systems.[69]

Recently R. Adler and V. Cohen have shown that the immune system is capable of a conditioned response.[70] Thus, when stress causes immunosupression, other stimuli associated with that stress may later cause immunosupression as well. The implications of this hypothetical model for causing disease are profound,[71] and may explain Eitinger's finding that survivors are more likely than controls to suffer from physical illness.[72]

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2. Horowitz, Mardi, (1986) *Stress Response Syndromes*, 2d Ed., Northvale, N.J.: Jason Aranson, p. 47, quoting Eitinger, Leo, (1969) Psychosomatic problems in concentration camp survivors, *J Am Psychoanal Assn* 13: 183-189.

3. This is confirmed by data on Vietnam veterans. Kulka, R.A.; Schlenger, W. E.; Fairbank, J.A.; Hough, R.L.; Jordan, B.K.; Marmar, C.R.; Weiss, D.S., (1988) *National Vietnam Veterans Readjustment Study (NVVRS): Description, Current Status, and Initial PTSD Prevalence Estimates*. Submitted to the U.S. Senate Committee on Veterans Affairs as Testimony for the Oversight Hearing on Post-Traumatic Stress Disorder. Research Triangle Institute; and Kulka, R.A.; Schlenger, W.E.; Fairbank, J.A.; Hough, R.L.; Jordan, B.K.; Marman, C.R.; Weiss, D.S., (1988) *Contractual Report of Findings from the National Vietnam Veterans Readjustment Study*. Research Triangle, NC: Research Triangle Institute.

4. Dr. Mardi Horowitz has developed a model to explain the natural history and phases of post-traumatic sequelae. His model is not trauma-specific and is intended to apply to survivors of a wide range of types of trauma including survivors of Nazi concentration camps, survivors of torture, survivors of sexual abuse, veterans of war and combat situations, prisoners of war, refugees from war, witnesses to human rights violations, survivors of kidnappings, and survivors of nuclear attack. While each survivor's personality, trauma, and post-trauma circumstances are unique and will influence the way in which that person responds to his or her trauma, Horowitz' model helps in understanding expected post-traumatic response.

According to Horowitz, the normal response to trauma is "outcry," followed by alternating phases of "denial" and "intrusion," "working through," and finally "completion." The process may be arrested at any stage or may become pathologic. Thus the fear, sadness, and rage associated with outcry can lead to panic, dissociative reactions, or exhaustion. The refusal to face a memory of a disaster during denial may lead to extreme avoidance and possible substance abuse to ease the pain. Intrusive thoughts may lead to disturbing, persistent images, compulsive reinactments, and recurrent thoughts of the event. The inability to complete the working through process may lead to psychosomatic responses, depression, anxiety reactions, or distortions of one's character reflected in the inability to love, feel emotions, or work. Horowitz, *supra*, n. 2, p. 41. For more on the denial and intrusion phases see n. 28 and accompanying text.

Dr. Tom Williams, a researcher who works with Vietnam veterans, has developed another model to describe post-traumatic sequelae. Williams identifies three phases of acute trauma response: shock, impact, and resolution. During the shock phase survivors experience immobilization and denial; during the impact phase they experience anxiety and anger, self-doubt, and depression; while during the resolution phase they test coping mechanisms and come to accept the trauma. Williams, Tom, (1987) Diagnosis and Treatment of Survivor Guilt — The Bad Penny, in Williams, *supra*, n. 1, p. 76.

Similar models have been postulated by researchers working with survivors of rape (Acosta, Carolyn A.; McHugh, Mary L., [1987] Sexual Assault Victims: The Trauma and the Healing, in Williams, Editor, *Post-Traumatic Stress Disorders: A Handbook for Clinicians, supra*, pp. 239-251. See also Warner, Carmen G., [1982] Counseling and Follow-up Interaction for the Adult Rape Victim, in Warner, Carmen and Braen, G. Richard, Editors, *Management of the Physically and Emotionally Abused: Emergency Assessment, Intervention, and Counseling*, Long Beach: Capistrano Press Ltd.), and refugees from war (Beiser, Morton, [1988] Influences of Time, Ethnicity, and Attachment on Depression in Southeast Asian Refugees, *Am J Psychiatry* 145: 46-51). Lenore Terr described the natural history over time of sequelae of Chowchilla schoolchildren who survived kidnapping (Terr, Lenore, [1983] Chowchilla Revisited: The Effects of Psychic Trauma Four Years After a School-bus Kidnapping, *Am J Psychiatry* 140: 1543-1550; Terr, Lenore, [1985] Children Traumatized in Small Groups, in Eth, Spencer; Pynoos, Robert S., *Post-Traumatic Stress Disorder in Children*, Washington, D.C.: American Psychiatric Press, pp. 47-70). Robert J. Lifton described the characteristic natural history of post-traumatic sequelae in Japanese nuclear holocaust survivors (Lifton, Robert J., [1967] *History and Human Survival*, New York: Vantage Books).

5. For some of the reasons PTSD is controversial, see Engdahl, Brian E.; Eberly, Raina E., The Effects of Torture and Other Captivity Maltreatment: Implications for Psychology, in Suedfeld, Peter, Editor, (in press) *Psychology and Torture*, Washington, D.C.: Hemisphere. For an in-depth discussion of the validity of PTSD see Breslau, N., Davis, G.C., (1987) Posttraumatic Stress Disorder, and subsequent commentary by Horowitz, Mardi J.; Weiss, Daniel S.; Marmer, C.; Lindy, J.D.; Green, B.L.; Grace, M.C.; and Ursano, R.J., *J Nerv Mental Disorders* 175: 25-276.

6. American Psychiatric Association, (1980) *Diagnostic and Statistical Manual of Mental Disorders*, (3rd Ed.) Washington, D.C.: American Psychiatric Press.

7. *Id.* A working group is now considering the inclusion of a victimization disorder for inclusion in the next edition of the DSM.

8. PTSD has been documented in other populations of survivors of human-induced stress. The National Vietnam Veterans Readjustment Study found that 15.2 percent, or 479,000, of the 3.14 million male Vietnam theatre veterans currently have PTSD. The rate for female Vietnam theatre veterans is 8.5 percent of 7,200 women. These figures are dramatically higher than rates for comparable Vietnam era veterans (2.5 percent male, 1.1 percent female) or civilian counterparts (1.2 percent male, 0.3 percent female.) Kulka, Richard A.; Schlenger, William E.; Fairbank, John A.; Hough, B. Kathleen; Marmar, Charles R.; Weiss, Daniel S., (November 7, 1988) Contractual Report of Findings from the National Vietnam Veterans Readjustment Study, Executive Summary, Research Triangle Institute, p. 2.

PTSD also has a high prevalence among ex-prisoners of war (POWs), a group whose traumas closely resemble those experienced by survivors of traumatic human rights abuses. According to one study, PTSD occurred in 28 percent of World War II Pacific Theatre POWs and 11 percent of European Theatre POWs, 42 percent of Korean war POWs, and two of three studied Vietnam war POWs (the third refused psychiatric examination). Oboler, Steven, (1987) American Prisoners of War — An Overview, in Williams, *supra*, n. 1, pp. 131-143.

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15. DSM-III-R, p. 248.

16. Arroyo, William, (1985) Children Traumatized by Central American Warfare, in Eth, Spencer; Pynoos, Robert, Editors, *Post-Traumatic Stress Disorder in Children*, Washington, D.C.: American Psychiatric Press, p. 113.

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18. Arroyo, *supra*, n. 16, p. 111.

19. Terr, Lenore, (1983), *supra*, n. 4, pp. 1543-1550; (1985) p. 53.

20. See chapter 10.

21. Data from the National Vietnam Veterans Readjustment Study confirm that many Vietnam veterans experienced a sense of foreshortened future both upon their return and for some, especially those with more severe problems, even at the present time. This suggests that this sequela is not confined to children, though it must be noted that many veterans were not much more than children when they went to Vietnam. *Supra*, n. 3.

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23. *Id.*

24. DSM-III-R, pp. 218-224. See also Fairbank, John A.; Keane, Terence M.; Malloy, Paul F., (1983) Some Preliminary Data on the Psychological Characteristics of Vietnam Veterans with Post-Traumatic Stress Disorder, *J Consult Clin Psychology* 51: 912, 917; Westermeyer, Joseph, (1988) DSM-III Psychiatric Disorders Among Hmong Refugees in the United States: A Point Prevalence Study, *Am J Psychiatry* 145: 197-202; Westermeyer, Joseph, (1986) Indochinese Refugees in Community and Clinic: A Report from Asia and the United States, in Williams, C.L.; Westermeyer, Joseph, Editors, *Refugee Mental Health in Resettlement Countries*, Washington, D.C.: Hemisphere, pp. 113-130.

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26. Genevieve Cowgill, (1989) personal communication.

27. DSM-III-R, p. 394.

28. Horowitz has developed models to explain how phases of intrusion and denial develop. He suggests that after a traumatic experience a person must revise his or her inner model. This revision takes considerable time and effort because each new aspect of the changed inner model must be accomplished by adjusting the older model. Furthermore each change may elicit painful responses and thereby inhibit or arrest the process before completion. Horowitz uses a concept he calls "incongruity" to explain the intrusion and denial phases. Survivors lose their sense of the world as an orderly place where injustices or cruelty do not occur. This incongruity in their pre-trauma and post-trauma worldviews is paired with an incongruity between their pre-trauma and post-trauma personalities. The pre-trauma personality enjoyed security and tranquility, and believed in the predictability of life. This personality cannot be harmonized with the traumatized personality that emerged afterward. Horowitz postulates that if the stress produced by this conflict becomes overwhelming, mental controls must be brought to bear to modulate it. These controls act as brakes to reduce anxiety and allow thoughts and feelings to recur in a more controlled manner. This "release, control, release, control" process reflects the occurrence of relative states of denial and intrusion. Each cycle causes subtle changes in the inner model as the individual struggles to obtain psychological mastery of the event, which Horowitz calls completion or congruence. Excessive use of controls or a lack of controls lead to non-completion due to either stopping the process or overwhelming emotional flooding and continued traumatization. Horowitz, *supra*., n. 2, p. 94.

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30. *Id.*, p. 312.

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34. Westermeyer found frequent medical conditions of a psychophysiological nature in 97 Hmong adult refugees in the United States. Westermayer, *supra*, n. 24. Garcia-Peltoniemi asserts that while somatic complaints are common in refugees, somatization disorder and hypochondriasis are not. These are commonly misdiagnosed as psychotic depression with somatic delusions. Garcia-Peltoniemi, Rosa E., (1987) Psychopathology in Refugees, Prepared for the National Institute of Mental Health's Refugee Assistance Program-Mental Health Technical Assistance Center of the University of Minnesota (Contract No. 278-85-0024 CH) pp. 40-41.

35. DSM-III-R, p. 257.

36. DSM-III-R, pp. 259-261.

37. Increased incidence of alcohol and drug dependence has been commented on by researchers studying Vietnam veterans. Egendorf, A., (1982) The Postwar Healing of Vietnam Veterans: Recent Research, *Hosp Comm Psychiatr* 33: 901-908; Yager, T.; Laufer, R.; Gallops, M., (1984) Some Problems Associated with War Experience in Men of the Vietnam Generation, *Arch Gen Psychiatry* 41: 327-333.

38. Garcia-Peltoniemi, *supra*, n. 34, pp. 37-38.

39. *Id.*, pp. 39-40.

40. See chapter 8.

41. Kaplan and Sadock, *supra*, n. 29, pp. 52-55; Carr, Arthur C., (1985) Grief, Mourning and Bereavement in Kaplan, Harold I.; Sadock, Benjamin J., Editors, *Comprehensive Textbook of Psychiatry/IV*, Baltimore: Williams and Wilkins, pp. 1286-1293.

42. Eitinger, Leo; Strom, Axel, (1973), *Mortality and Morbidity after Excessive Stress*, New York: Humanities Press.

43. See, *e.g.*, Egendorf, A. (1982) The Postwar Healing of Vietnam Veterans: Recent

Research, *Hosp Comm Psychiatry* 33: 901-908; New Study Blames Vets' Problems on Combat, *San Francisco Chronicle*, July 25, 1985, p. 4. But, see Health Status of Vietnam Veterans Part I: Psychosocial Characteristics, (1988) *JAMA* 259: 2701-2707. In that study researchers found that psychological and emotional problems in Vietnam veterans did not lower their social and economic attainment as a group when adjusted for characteristics at entry to the service.

44. Danieli, Yael, (1988) The Heterogeneity of Postwar Adaptation in Families of Holocaust Survivors, in Braham, Randolph L., Editor, *The Psychological Perspectives of the Holocaust and of Its Aftermath*, Boulder: Social Science Monographs, p. 115.

45. *Id.*, pp. 120-121.

46. Bittner, Egon, (1968) Life Adjustment after Severe Persecution, *Amer J Psychiat* 124: 87-94.

47. Leo Eitinger, following interviews with more than 2,000 concentration camp survivors, found that retention of the ability to make one's own decisions had a positive correlation with post-traumatic outcome. Eitinger, Leo, (1974) Coping with Aggression, *Mental Hlth Soc* 1: 279-301.

48. *The best biological model for learned helplessness involves exposure of animals to inescapable shock, which has widespread behavioral and physiological consequences. "Animals who have been actively prevented from escaping severe physical stress, such as electric shock, loud noise, or submersion in cold water, later show (1) deficits in learning to escape from novel aversive situations, (2) a decrease in motivation to learn new contingencies, and (3) chronic evidence of subjective distress. For example, after having been given one session of inescapable shock, dogs fail to avoid shock in a different environment shortly afterwards. When placed in a shuttle box they fail to jump across a barrier to terminate shock. Instead they passively lie down, enduring repeated shocks, while urinating, defecating and whining. The impression that they have given up has led to the term learned helplessness. Controlled experiments have established that the helplessness syndrome is not merely due to shock per se, but rather to the lack of control that the animal has in terminating shock. In addition to deficits in learning and motivation, such inescapable aversive events in animals have been shown to produce lowered social dominance, immunosuppression and increased incidence of tumor genesis."* (van der Kolk, Bessel; Greenberg, Mark; Boyd, Helene; Krystal, John, (1985) Inescapable Shock, Neurotransmitters, and Addiction to Trauma: Toward a Psychobiology of Post Traumatic Stress, Biol Psychiatry 20: 316.)

49. Krystal, Henry, (1987) The Paradigm of Adult Catastrophic Trauma and Infantile Trauma. Paper presented annual meeting of Society of Traumatic Stress Disorders, Baltimore, Md.

50. Nemiah, J.C.; Sifneos, P.C., (1970) Affect and Fantasy in Patients with Psychosomatic Disorders, in Hill, O., Editor, *Modern Trends in Psychosomatic Medicine*, London: Butterworth, p. 126.

51. Knapp, Peter H., (1985) Current Theoretical Concepts in Psychosomatic Medicine, in Kaplan and Sadock, *supra*, n. 41, p. 1119.

52. Lin, Keh-Ming; Masuda, Minoru, (1983) Impact of the Refugee Experience, *Bridging Cultures: Southeast Asian Refugees in America*, Los Angeles: Special Service for Groups, Asian American Community Mental Health Training Center p. 34.

53. *Id.*, p. 33.

Westermeyer states that the rate of psychiatric disorders among Hmong refugees in the United States is at least twice that of the U.S. population (43 percent versus 15-20 percent) with a large percentage having chronic adjustment disorder or chronic acculturation syndrome that does not resolve within six to 10 years after migration. The phenomenon was previously called "refugee neurosis" and was thought to result from the stress of acculturation and the failure of complete acculturation combining to cause a lowered level of coping and an increased self-report of symptoms. Westermeyer, (1988), *supra*, n. 24.

When the Vietnamese first arrived in America anxiety symptoms prevailed; one year later they were less anxious, but were frustrated and homesick. As the refugees became more adjusted to their surroundings depression paradoxically increased. It took several months for refugees to realize their situation and to psychologically "arrive." Lin, Keh-Ming; Masuda, Minoru; Tazuma, Laurie, (1982) Problems of Vietnamese Refugees in the United States, in Nann, Richard C., Editor, *Uprooting and Surviving Adaptation and Resettlement of Migrant Families and Children*, Dordrecht, Holland: D. Reidel, p. 22.

54. Roth, Walton T., (1988) The Role of Medication in Post-Traumatic Therapy, in Ochberg, Frank, Editor, *Post-Traumatic Therapy and Victims of Violence*, New York: Brunner/Mazel, p. 41.

55. Selye, Hans, (1956) *The Stress of Life*, New York: McGraw Hill; Kandel, Eric R., (1982) Environmental Determinants of Brain Architecture and of Behavior: Early Experience and Learning, in Kandel, E.R.; Schwartz, J.H., Editors, *Principles of Neuroscience*, New York: Elsevier, North Holland, pp. 620-632; Calabrese, Joseph R.; Kling, Michael A.; Gold, Philip W., (1987), Alterations in Immunocompetence during Stress, Bereavement, and Depression: Focus on Neuroendocrine Regulation, *Am J Psychiatry* 144: 1123-1134.

56. The locus coeruleus exerts control over the autonomic nervous system and is the primary source of noradrenergic innervation of the limbic system, the cerebral cortex, the cerebellum, and to a lesser degree the hypothalamus. It also plays a major role in memory retrieval by means of neural connections to the hippocampus, amygdala, and temporal neocortex, all of which are involved in memory. van der Kolk, Bessel A., (1988) The Biological Response to Psychic Trauma, in Ochberg, *supra*, n. 54, p. 30.

57. van der Kolk, *et al.*, *supra*, n. 48.

58. McNamara, James O.; Bonhaus, Douglas W.; Shin, Cheolsu; Crain, Barbara J.; Gellman, Randy L.; Giacchino, Jeannie L., (1985) The Kindling Model of Epilepsy: A Critical Review, *CRC Crit Rev Clin Neurobiol* 1: 341-391. Post and Kopanda also postulate that repetitive psychological stress may be capable of activating critical limbic mechanisms involved in the modulation of emotional and cognitive behavior, and that these mechanisms may allow environmental events to sensitize patients in the same way. Post, Robert M.; Kopanda, Richard, (1976) Cocaine, Kindling, and Psychosis, *Am J Psychiatry* 133: 627-634.

59. *Id.*

60. *Id.*

61. *Id.*

62. Kandel, *supra*, n. 55.

63. Breier, Alan; Albus, Margot; Pickar, David; Zahn, Theodor P.; Wolkowitz, Owen M.; Paul, Steven M., (1987) Controllable and Uncontrollable Stress in Humans: Alterations in Mood and Neuroendocrine and Psychophysiological Function, *Am J Psychiatry* 144: 1419-1425.

64. *Id.* In their study, hypothalamic pituitary function was measured by adrenocorticothrophic hormone (ACTH), and increased sympathetic activity was reflected by plasma epinephrine and increased electrodermal activity.

65. *Id.* In addition, Thomas R. Kosten and John Krystal noted genetic variation in sensitivity to learned helplessness and catecholamine sensitivity differences suggesting at least an element of natural resistance or heightened sensitivity in reactions to stressors. They have also noted that previous mastery decreases the incidence of learned helplessness. Paper presented at Society for Traumatic Stress Studies annual meeting, (1987) Baltimore, Md.

66. Blanchard, Edward B.; Kolb, Lawrence C.; Pallmeyer, Thomas P.; Gerardi, Robert J., (1983) A Psychophysiologic Study of Post Traumatic Stress Disorder in Vietnam Veterans, *Psychiatric Q* 54: 220-228; Malloy, Paul F.; Fairbank, John A.; Keane, Terence M., (1983) Validation of a Multimethod Assessment of Posttraumatic Stress Disorders in Vietnam Veterans, *J Consult Clin Psychology* 51: 488-494.

67. Kosten and coworkers investigated urinary norepinephrine and epinephrine elevations in hospitalized PTSD patients. The mean norepinephrine levels in PTSD indicated sympathetic nervous system overactivity (which would be expected) and was greater than that found in bipolar, major depressive disorder, paranoid schizophrenic, and undifferentiated schizophrenic patients. These levels were sustained throughout the hospitalization. Increased norepinephrine levels have been linked with diverting anger outwardly and with hypervigilance. The mean epinephrine levels in PTSD patients were higher than major depressive disorder, paranoid schizophrenics, and undifferentiated schizophrenics, signifying more adrenal activity. It was not higher than that found in bipolar patients. Neither of these levels could be explained by medication use or differences in the level of activity. The measured test results were predominantly in the normal ranges thus suggesting that hormonal levels may have to change less to cause psychological dysfunction than to cause endocrinologic disorder. Kosten, Thomas R.; Mason, John W.; Giller, Earl L.; Ostroff, Robert B.; Harkness, Laurie, (1987) Sustained Urinary Norepinephrine and Epinephrine Elevation in Posttraumatic Stress Disorder, *Psychoneuroendocrinology* 12: 13-20.

Mason and colleagues investigated urinary free-cortisol levels in the same group of patients described by Kosten above. They found that these levels were significantly lower than in all the other groups except PTSD and paranoid schizophrenia. This result is surprising because a low urinary cortisol would not be expected with overt signs of anxiety and depression. They concluded that some specific psychological mechanism exerts a selective inhibitory influence in the pituitary adrenal axis. It has been established that certain psychological defenses, especially denial, can exert a strong suppressive effect on urinary corticosteroid levels even when the subject is exposed to new stress. Overstimulation of the adrenal cortex by ACTH in these persons produced normal responses (that is, the adrenal itself worked properly upon artificial stimulation) suggesting a psychological suppressive mechanism of ACTH stimulation. Mason, John W.; Giller, Earl L.; Kosten Thomas R.; Ostroff, Robert B.; Podd, Linda, (1986) Urinary Free-cortisol Levels in Posttraumatic Stress Disorder Patients, *J Ment Nerv Dis* 174: 1-5.

Mason and colleagues then calculated a urinary norepinephrine to cortisol ratio and were able to discriminate all groups from the PTSD patients. The use of this ratio on an individual basis had about 80 percent sensitivity. Mason, John W.; Giller, Earl L.; Kosten, Thomas R.; Harkness, Laurie, (1987) Elevation of Urinary Norepinephrine/Cortisol Ratio in Post-traumatic Stress Disorder, Dept. of Psychiatry, Yale U. School of Medicine, West Haven V.A. Medical Ctr., unpublished.

Giller and coworkers measured platelet receptors (receptors from the central nervous system are unavailable for measurement in humans) and found a decrease in certain platelet receptors in PTSD, bipolar disorder, and manic patients. These researchers also found altered platelet affinities in PTSD and personality disorder patients. They believe that the high levels of catecholamines may be related to changes in the receptor number and affinity in both peripheral platelet sites and in the central nervous system. Giller, Earl L.; Southwick, Steven M.; Perry, Bruce D., (1987) Blood Element Adrenergic Receptors in Post Traumatic Stress Disorder and Other Affective Disorders, (Abstract), *Proc Soc Biol Psychiatry*, No. 285

68. Calabrese, Joseph R.; Kling, Mitchel A.; Gold, Philip W., (1987) Alterations in Immunocompetence During Stress, Bereavement, and Depression: Focus on Neuroendocrine Regulation, *Am J Psychiatry* 144: 1123-1134.

69. *Id.* They also note that lymphokines (substances secreted by white blood cells) may gain access to the central nervous system and may promote adaptive endocrine and behavioral responses to an invader that have potential survival value. During the immune response to an antigen (foreign substance) there is evidence of decreased central nervous system norepinephrine turnover and an increased firing in specific hypothalamic nuclei. Decreased norepinephrine content in peripheral lymphoid organs are seen with these changes.

Furthermore recalling the increased levels of epinephrine and norepinephrine in PTSD patients described above, it is known that both norepinephrine and epinephrine are potent regulators of the immune system (as indicated by the use of epinephrine in acute anaphylaxis) and may be responsible for the predominance of T cell abnormalities as compared with B cell abnormalities through their effect on glucocorticoid production. Linn and coworkers, using the HPA checklist as a measure of depression in bereaved subjects, found that those who were more depressed had reduced responses to mixed lymphocyte culture. They also found that examination stress or loneliness reduced natural killer cell activity. Linn, M.W.; Linn B.S.; Jensen B.S., (1984) Stressful Events Dysphoric Mood and Immune Responsiveness, *Psychol Rep* 54: 219-222. Similarly, Calabrese and colleagues reported, "[e]xtreme physical stress diminishes immunocomptence with quantitative changes such as decreased T cell number and diminished lymphocyte responsivitiy." Calabrese, *et al.*, *supra*, n. 68.

70. Adler, R.; Cohen, V., (1975) Behaviorally Conditioned Immunosupression, *Psychosomatic Med* 37: 333-340. They paired cyclophosphamide (a drug causing immunosuppression) with saccharin (a sweetener with no immunomodulation properties). When animals were given saccarin at a later time they had an immunosuppressed response as if they also had been given cyclophosphamide. They were later able to use this conditioned stimulus response to immunosuppress in a therapeutic way using only placebo; they were able to decrease morbidity and mortality in diseased animals requiring immunosuppression as treatment.

71. For an in-depth discussion of other biologically active substances and stress see Gold, Philip W.; Goodwin, Frederick K.; Chrousos, George P., (1988) Clinical and Biochemical Manifestations of Depression: Relation to the Neurobiology of Stress, *N Engl J Med* 31: 348-353, 413-420; Golden, Robert N.; Putter, William Z., (1986) Neurochemical and Neuroendocrine Dysregulation in Affective Disorders, *Psychiatric Clin N Am* 9: 312-327, Philadelphia: W.B. Saunders; Rothschild, Anthony J., (1988) Biology of Depression, in Frazier, Shervert H., *The Medical Clinics of North America: Anxiety and Depression*, Philadelphia: W. B. Saunders, pp. 765-790; Teicher, Martin H., (1988) Biology of Anxiety, in Frazier, S.H., *supra*, pp. 791-814.

72. Eitinger and Strom, *supra*, n. 42.

APPENDIX D

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Children's Reaction to Trauma

I. Caveats about Children

- A. Regression
- B. Double Loss
- C. Live in Present
- D. Growth
- E. Change

II. Developmental Stages of the Child

A. *Age: Birth - 2 Years*

1. Language capability: pre-verbal.
2. Communication mode: physical activity.
3. Thought processes: distinguishes self from others and other things.
4. Growth emphasis: sensory perception and response.
5. Primary need: physical human contact for reassurance.
6. Primary relationship: with caretaker(s).

B. *2 Years - 6 Years: Pre-School*

1. Language capability: development of language/verbal expression.
2. Communication mode: expression of feelings primarily through play, but communication of needs often through words.
3. Thought processes:
    - pre-conceptual thinking but engages in primitive problem-solving.
    - active imagination but grounded in reality — fantasies are about things similar to those they have experienced.
    - minimal concept of time and space.
    - inability to concentrate on any one thing for more than a few minutes.
4. Growth emphasis: physical independence; dressing, feeding, and washing self.

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5. Primary need: need for nurturing.
   - "who will take care of me?"
   - wants structure and security.
6. Primary relationship: with family.

C. ***6 Years - 10 Years: School Age***

1. Language capability: language well developed.
2. Communication mode: Still uses play for primary expression but supplements play with emotive language.
3. Thought processes:
   - uses problem-solving techniques but also trial and error approach to problems.
   - understands time and space concepts.
   - strong orientation to the present but has some sense of future and past.
   - makes choices.
4. Growth emphasis: toward independence in establishing new relationships; exploring new environments.
5. Primary need: trust.
6. Primary relationship: still family but movement toward establishing strong peer relationships.

D. ***10 Years - 12 Years: girls' pre-adolescence***
12 Years - 14 Years: boys' pre-adolescence

1. Language capability: Language may be more advanced than concepts.
2. Communication mode: "acting out" is common form of expression; poetry developing.
3. Thought processes:
   - prone to extreme feelings and idealized emotions or life styles.
   - judgmental about the world and self.
   - thoughts become integrated with feelings and engender beliefs, biases, and prejudices.

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4. Growth emphasis:
    - towards emotional independence: involves swings back and forth from child-like states to imitations of adult life.
    - growth of sexuality and concern with sexual identities.
    - emotional turmoil heightened by physical changes.
5. Primary need: support and self-esteem.
6. Primary relationship: back and forth from family to peers.

E. ***12/14 Years - Adult***

1. Language capability: uses and creates language to express self.
2. Communication modes: Drama and physical activity is preferred recreation since it provides a socially accepted way of acting out feelings; poetry still intense.
3. Thought processes:
    - understands "cause and effect."
    - can consider possibilities and explore options without experiencing them.
    - judgmental about everything — sees things in black and white.
    - can conceive of future activities but does not think of future in terms of self — the Peter Pan dream.
    - prone to taking irresponsible risks and failing to think through the consequences of actions.
    - reflection on symbols and possibilities.
    - decentering.
    - development of critical faculties.
    - emotional turmoil may include periods of depression and euphoria.
4. Growth emphasis: independence from adult world — particular target of conflict is usually parents.
    - ego-orientation and self-centeredness.
    - feels strong need for privacy and secrecy.
    - body and sexual image is highly important.
    - sense of immortality.

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    - creation of dance, style, world.

5. Primary need: stability, limits and security.
6. Primary relationship: with peers.

III. Child Reactions To Trauma

A. **Overview:** Children's reaction to a trauma will involve not only the impact of the catastrophe on their lives (what they saw, heard, felt, smelled and so on) but a sense of crisis over their parents' reactions. The presence or absence of parents and terror over a frightening situation — one that has rendered the children's parents helpless — all contribute to children's distress.

"A central theme that emerges from exploration of children's responses to disaster situations is that, in a way that is not generally appreciated, they, too, experience fear of death and destruction... Particularly influential in the young child's experience are the presence or absence of his parents and the terror of overwhelming physical forces that seem to render the 'all powerful' adult parents frightened and powerless."

B. ***Birth - 2 Years***

1. High anxiety levels manifested in crying, biting, throwing objects, thumb sucking, and agitated behavior.
2. While it is unlikely that the child will retain a strong mental memory of the trauma, the child may retain a physical memory.

C. ***2 Years - 6 Years: pre-school***

1. Children may not have the same level of denial as do adults so they take in the catastrophe more swiftly.
2. Engage in reenactments and play about the traumatic event — sometimes to the distress of parents or adults.
3. Anxious attachment behaviors are exhibited toward caretakers — may include physically holding on to adults; not wanting to sleep alone; wanting to be held.
4. May become mute, withdrawn and still.
5. Manifest a short "sadness span" but repeat sadness periods over and over.
6. Regress in physical independence — may refuse to dress, feed, or wash self; may forget toilet training; may wet bed.
7. Sleep disturbances, particularly nightmares are common.

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8. Any change in daily routines may be seen as threatening.
9. Does not understand death (no one does) and its permanency — reaction to death may include anger and a feeling of rejection.

D. ***6 Years - 10 Years: School age***

1. Play continues to be the primary method of expression. Often art, drawing, dance or music may be integrated in the play.
2. The sense of loss and injury may intrude on the concentration of the child in school.
3. Radical changes in behavior may result — the normally quiet child becoming active and noisy; the normally active child becoming lethargic.
4. May fantasize about event with "savior" ending.
5. Withdrawal of trust from adults.
6. May become tentative in growth towards independence.
7. Internal body dysfunctions are normal — headaches, stomach aches, dizziness.
8. May have increasing difficulty in controlling their own behaviors.
9. May regress to previous development stages.

E. ***10 Years - 12 Years: girls' pre-adolescence***
12 Years - 14 Years: boys' pre-adolescence

1. Become more childlike in attitude.
2. May be very angry at unfairness of the disaster.
3. May manifest euphoria and excitement at survival.
4. See symbolic meaning to pre-disaster events as omens and assign symbolic reasons to post-disaster survival.
5. Often suppress thoughts and feelings to avoid confronting the disaster.
6. May be self-judgmental about their own behavior.
7. May have a sense of foreshortened future.
8. May have a sense of meaninglessness or purposelessness of existence.
9. Psychosomatic illnesses may manifest themselves.

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F. ***12/14 Years - 18 Years***

1. Adolescents most resemble adult post-traumatic stress reactions.
2. May feel anger, shame, betrayal and act out their frustration through rebellious acts in school.
3. May opt to move into adult world as soon as possible — to get away from the sense of disaster and to establish control over their environment.
4. Judgmental about their own behavior and the behavior of others.
5. Their survival may contribute to the sense of immortality.
6. They are often suspicious and guarded in their reaction to others in the aftermath.
7. Eating and sleeping disorders are common.
8. Depression and anomie may plague the adolescent.
9. May lose impulse control and become a threat to other family members and him/herself.
10. Alcohol and drug abuse may be a problem as a result of the perceived meaninglessness of the world.
11. Fear that the disaster or tragedy will repeat itself adds to the sense of a foreshortened future.
12. May have psychosomatic illnesses.

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Some Coping Strategies for Children

A. Rebuild and reaffirm attachments and relationships. Love and care in the family is a primary need. Extra time should be spent with children to let them know that someone will take care of them and, if parents are survivors, that their parents have reassumed their former role as protector and nurturer is important. Physical closeness is needed.

B. It is important to talk to children about the tragedy — to address the irrationality and suddenness of disaster. Children need to be allowed to ventilate their feelings, as do adults, and they have a similar need to have those feelings validated. Reenactments and play about the catastrophe should be encouraged. It may be useful to provide them with special time to paint, draw, or write about the event. Adults or older children may help pre-school children reenact the event since pre-school children may not be able to imagine alternative "endings" to the disaster and hence may feel particularly helpless.

C. Parents should be prepared to tolerate regressive behaviors and accept the manifestation of aggression and anger especially in the early phases after the tragedy.

D. Parents should be prepared for children to talk sporadically about the event — spending small segments of time concentrating on particular aspects of the tragedy.

E. Children want as much factual information as possible and should be allowed to discuss their own theories about what happened in order for them to begin to master the trauma or to reassert control over their environment.

F. Since children are often reluctant to initiate conversations about trauma, it may be helpful to ask them what they think other children felt or thought about the event.

G. Reaffirming the future and talking in "hopeful" terms about future events can help a child rebuild trust and faith in his own future and the world. Often parental despair interferes with a child's ability to recover.

H. Issues of death should be addressed concretely.

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APPENDIX E

Facts for Families

from the American Academy of Child and Adolescent Psychiatry

No. 8 (9/91)

CHILDREN AND GRIEF

When a family member dies, children react differently from adults. Preschool children usually see death as temporary and reversible--a belief reinforced by cartoon characters who "die" and "come to life" again. Children between five and nine begin to think more like adults about death, yet they still believe it will never happen to them or anyone they know.

Adding to a child's shock and confusion at the death of a brother, sister or parent is the unavailability of other family members, who may be so shaken by grief that they are not able to cope with the normal responsibility of child care.

Parents should be aware of normal childhood responses to a death in the family, as well as danger signals. According to child and adolescent psychiatrists, it is normal during the weeks following the death for some children to feel little immediate grief or persist in the belief that the family member is still alive. But long-term denial of the death or avoidance of grief is unhealthy and can later surface in more severe problems.

A child who is frightened about attending a funeral should not be forced to go; however, some service or observance is recommended, such as lighting a candle, saying a prayer or visiting the grave site.

Once children accept the death, they are likely to display their feelings of sadness on and off over a long period of time, and often at unexpected moments. The surviving relatives should spend as much time as possible with the child, making it clear that the child has permission to show his or her feelings openly or freely.

The person who has died was essential to the stability of the child's world, and anger is a natural reaction. The anger may be revealed in boisterous play, nightmares, irritability or a variety of other behaviors. Often the child will show anger towards the surviving family members.

After a parent dies, many children will act younger than they are. The child may temporarily become more infantile, demanding food, attention and cuddling, and talking "baby talk."

Younger children believe they are the cause of what happens around them. A young child may believe a parent, grandparent, brother or sister died because he or she had once "wished" the person dead. The child feels guilty because the wish "came true." Some danger signals to watch for:

- An extended period of depression in which the child loses interest in daily activities and events.
- Inability to sleep, loss of appetite, prolonged fear of being alone.
- Acting much younger for an extended period.
- Excessively imitating the dead person; repeated statements of wanting to join the dead person.
- Withdrawal from friends.
- Sharp drop in school performance or refusal to attend school.

These warning signs indicate that professional help may be needed. A child and adolescent psychiatrist can help the child accept the death and assist the survivors in helping the child through the mourning process.

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The AACAP has a membership of [illegible] child and adolescent psychiatrists - physicians with at least 5 years of training beyond medical school in adult, child and adolescent psychiatry.

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33. Conduct Disorders
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35. Tic Disorders
36. Helping Children After a Disaster
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Facts for Families

from the American Academy of Child and Adolescent Psychiatry

No. 36 (7/91)

HELPING CHILDREN AFTER A DISASTER

A catastrophe such as an earthquake, hurricane, tornado, fire or flood is frightening to children and adults alike. It is important to acknowledge the frightening parts of the disaster when talking with a child about it. Falsely minimizing the danger will not end a child's concerns. Several factors affect a child's response to a disaster.

The way children see and understand their parents' response is very important. Children are aware of their parents' worries most of the time but they are particularly sensitive during a crisis. Parents should admit their concerns to their children, and also stress their abilities to cope with the situation.

A child's reaction also depends on how much destruction he or she sees during and after the disaster. If a friend or family member has been killed or seriously injured, or if the child's school or home has been severely damaged, there is a greater chance that the child will experience difficulties.

A child's age affects how the child will respond to the disaster. For example, six-year-olds may show their concerns about a catastrophe by refusing to attend school, whereas adolescents may minimize their concerns but argue more with parents and show a decline in school performance. It is important to explain the event in words the child can understand.

Following a disaster, people may develop Post-Traumatic Stress Disorder (PTSD), which is psychological damage that can result from experiencing, witnessing or participating in an overwhelmingly traumatic (frightening) event. Children with this disorder have repeated episodes in which they re-experience the traumatic event. Children often relive the trauma through repetitive play. In young children, distressing dreams of the traumatic event may change into nightmares of monsters, of rescuing others or of threats to self or others.

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PTSD rarely appears during the trauma itself. Though its symptoms can occur soon after the event, the disorder often surfaces several months or even years later.

Parents should be alert to these changes:

- Refusal to return to school and "clinging" behavior, shadowing the mother or father around the house;
- Persistent fears related to the catastrophe (such as fears about being permanently separated from parents);
- Sleep disturbances such as nightmares, screaming during sleep and bedwetting, persisting more than several days after the event;
- Loss of concentration and irritability;
- Behavior problems--for example, misbehaving in school or at home in ways that are not typical for the child;
- Physical complaints (stomachaches, headaches, dizziness) for which a physical cause cannot be found;
- Withdrawal from family and friends, listlessness, decreased activity, preoccupation with the events of the disaster.

Professional advice or treatment for children affected by a disaster--especially those who have witnessed destruction, injury or death--can help prevent or minimize PTSD. Parents who are concerned about their children can ask their pediatrician or family doctor to refer them to a child and adolescent psychiatrist.

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APPENDIX F

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6

10. Children and Traumatic Human Rights Abuse

In many countries children are arrested, detained, and subjected to torture or other forms of mistreatment. In others they are helpless witnesses to violent arrests and house searches or to the killing or maiming of others. Many must endure the ongoing trauma and hardships of war or flight from conflict or starvation-ridden areas.[1] Children may also be traumatized by the arrest, torture, prolonged detention, or murder of a parent or close family member. In addition, children of traumatized parents, including those who were traumatized before their children were born, may suffer intergenerational effects of their parents' post-traumatic sequelae.

The impact of psychological trauma on children has been documented in a wide variety of contexts including traumatic human rights abuses, child abuse, kidnapping, disasters, parental homicide, parental suicide, and war.[2] The earliest studies of traumatized children focused on survivors of Nazi persecution who were children at the time of their trauma.[3] Studies of physically, psychologically, or sexually abused children were first conducted in the 1960s.[4] At that time investigators focused on physical damage and mental sequelae such as retardation. As the field developed, greater emphasis was placed on test taking, interaction with other children, reactions to strange surroundings, or IQ-type tests.[5]

Beginning in 1983, investigators began focusing on the symptoms of post-traumatic stress disorder (PTSD) in children.[6] *The Diagnostic and Statistical Manual of Mental Disorders*, (3rd edition, revised) (DSM III[R]) mentions special manifestations of PTSD in children. These include repetitive play in which themes or aspects of the trauma are expressed, and loss of recently acquired developmental skills such as toilet training or language skills.[7]

Lenore Terr, who studied children who were victims of a school bus kidnapping in Chowchilla, California, found that following severe unanticipated trauma,

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children differed from adults in several ways:[8]

1. Children older than 3 or 4 do not become amnestic and do not employ denial or massive repression.
2. Children usually do not demonstrate psychic numbing, though this may occur with episodes of repeated dehumanization or with abuse that is somewhat expected.
3. Children do not experience visual flashbacks; however, they can daydream at will.
4. Children's work performance (school) suffers for a relatively short period in contrast to the decline in performance in adults. This may be due to the lack of denial, flashbacks, and numbing seen in adults.

The following occurred in both children and adults, but to a greater degree in children:

5. Post-traumatic play and reenactment.
6. Time distortion.
7. A foreshortened view of the future.

Terr also found that in children traumatized in groups there is a lack of group cohesiveness. Unlike veterans' groups in which members had formal training in anticipation of a common experience and subsequently thrived on combat unit reunions, children preferred not to reunite because doing so reminded them of the traumatic experience they wanted to forget.

Calvin Frederick found that the most common behavioral and psychological symptoms in traumatized children are bad dreams, persistent thoughts of the trauma, a belief that the trauma will be repeated, conduct disorders, hyperalertness, avoidance of symbolic events or things, psychophysiological disturbances, and, in younger children, regression.[9] In a study in which he compared the incidence of PTSD in children exposed to natural disasters, molestation, or physical abuse with adults exposed to natural disasters, human-induced catastrophes, hostage taking, or physical assault, the incidence of PTSD among children was higher.[10] Similarly, Robinson found that among survivors of Nazi persecution, those who were persecuted before the age of 17 were more seriously ill many years later than a control group of children who had escaped to the Soviet Union during World War II.[11]

EFFECTS OF TRAUMA ON CHILDREN

Children's and adults' perceptions of, understandings about, and expressions of events are not identical and these differences complicate diagnosis, choice of treatment methods, and prognosis. While children suffer many of the same post-traumatic sequelae as adults, important variables when assessing children are age, developmental stage, dependency on care givers and the effect the trauma has had on the child's care giver, socioeconomic changes, physical health and nutrition, and the child's perceptions of changes in his or her care and environment.

Age is important because as children grow older their personalities, patterns of attachment, experience, and conceptual frameworks change. For example, infants traumatized before the development of verbal skills may have memories of traumatic events that they are unable to express in words. Instead they may express them through play.[12] But small children traumatized once language ability has begun to develop may have some verbal recollection of events. Research with children who were persecuted by the Nazis confirms that younger children have more severe psychopathology than those who were older when they were persecuted. The degree of psychopathology in children who were in hiding did not differ from those interned in concentration camps.[13]

Reactions to trauma also vary with the developmental level of the child at the time of trauma. According to Carol Mowbray, a preschool child's reactions to trauma include fears and worries, somatic problems, restitutive play, compulsions, regression, separation anxiety, nightmares, and sleep disturbances. The school age child has the same responses plus fantasies, anger, hostility, belligerence, interpersonal problems, school problems and phobias, guilt, chronic sadness, depression, and self-deprecation. Adolescent reactions include fears and worries, nightmares and sleep disturbances, fantasies, anger, hostility and belligerence, interpersonal problems, school problems and phobias, apathy and withdrawal, guilt, personality change, chronic sadness and depression, self-deprecation, intellectualization including rationalization, anxiety, and acting out.[14] Similar problems have been observed in abused and neglected children.[15] Trauma during adolescence interrupts the last phase of childhood and often thrusts upon unprepared teenagers adult roles in relation to the family or society.

A child's dependency on caregivers and the effect the trauma has had on the child's care givers are other important variables. The degree of dependency varies with age. For example, a toddler's dependence on others for basic necessities such as food, shelter, and safety is different from that of a 15-year-old. The "disappearance," death, detention, or other forced separation from the care giver will have a tremendous effect on any child, but that effect is magnified in the child whose dependency needs are greater. Even if the care giver is physically in the home, his or her ability to provide love, affection, security, and time to the child may be impaired as a result of post-traumatic sequelae, absence or loss of a loved one, or financial difficulties. Older, more independent children may be better able to cope with these family stresses than younger, more dependent ones.

Changes in social or economic status that may occur as a result of or in connection with trauma are other important variables in assessing post-traumatic sequelae in children. A child may have to move from one community to another, change schools, or endure economic hardship. Those who were forced to flee their countries must cope with the added and intertwined stresses of being refugees. Even if a child remains in the same community, he or she may be socially ostracized because of family membership. Friends may no longer be permitted to associate with the traumatized child because of their families' fears of government reprisals. Former playmates may call them names or ridicule their parents.

Physical health and nutritional status are also important determinants of post-traumatic sequelae. A child who is malnourished or ill is in a poorer position to survive trauma, is more likely to be injured, and is more severely limited in his or her reparative capacity than a well-nourished healthy child. Malnutrition may also lead to more severe, late mental and physical sequelae such as mental retardation and permanent orthopedic deformities.[16] Children with significant psychological problems also have a poorer prognosis after trauma. Psychologically impaired children may act in ways that make trauma more likely, or be unable to develop creative plans for avoiding trauma. In addition, post-traumatic sequelae may complicate their existing psychological problems.

A child's perceptions about what occurred will also color his or her post-traumatic responses. For example, children are egocentric. They believe that everything is oriented toward them and, as a result, they tend to lack empathy toward others.[17] If a traumatic event occurs, a child associates it with something he or she did. A child's perception of death also colors his or her reactions to trauma:

> *At ages three to five, death is not permanent, but merely living on under changed circumstances. Any sorrow associated with death is because of separation. From ages six to eight, death is seen as an external agent, often monsterlike, who can catch you and take you away. But if you see it coming in time, you can escape. By age nine, however, children have attained a more adult-like concept of death as the end of life.... Young children may experience less death anxiety because they see death as impermanent or escapable.... Separation is much more anxiety-producing for them than for older children and adolescents.*[18]

These perceptions must be taken into account if treatment is to be successful.

CHILDREN OF SURVIVORS

Severe trauma also has intergenerational consequences. Children of parents who have survived diverse traumatic experiences such as the Nazi Holocaust, imprisonment as a prisoner of war, or the "disappearance" of a spouse seem to be affected in similar ways. As one child of survivors of the Nazi Holocaust wrote:

> *It was suddenly clear to me, how could people go through an experience like that and not expect it to have a residual effect on their children.... Many are ignorant of the specifics of what their parents went through. Yet the Holocaust is no more a set historical event locked away in textbooks and commemoration ceremonies than it is for their parents.... They possess as their own the emotions that grew out of their parent's uprooting, persecution, and near extermination.* [19]

Like survivors, many children of survivors have difficulty expressing their parent's trauma and its meaning to them. They often feel stigmatized. As another child of survivors of the Nazi Holocaust wrote:

> *For years it lay in an iron box buried so deep inside me that I was never sure just what it was. I knew I carried slippery, combustible things more secret than sex and more dangerous than any shadow or ghost. Ghosts had shape and name. What lay inside my iron box had none. Whatever lived inside me was so potent that words crumbled before they could describe.... The box became a vault, collecting in darkness, always collecting, pictures, words, my parents' glances, becoming loaded with weight. It sank deeper as I grew older, so packed with undigested things that finally it became impossible to ignore. . . . I set out on a secret quest, so intimate I did not speak of it to anyone. I set out to find a group of people who like me, were possessed by a history they had never lived. I wanted to ask them questions, so that I could reach the most elusive part of myself.*[20]

In trying to give their children the benefit of their experiences and teach them how to survive successfully in the world, Nazi Holocaust survivors unconsciously transmit by word and deed the conditions under which they lived during the war. Features of parent-child interactions in families of survivors of the Nazi Holocaust have been characterized by overprotection (in an effort to help the child cope better by constantly warning of possible disappointments and disasters), inducing guilt (in that the child's life is much better than the parents' childhood or adulthood), inducing suspicion toward the non-Jewish world (causing the child to choose between loyalty to the parents or associating with gentiles), the burdensome expectation that the child provide fulfillment and feeling of worth in the parents' lives, and, in some cases, the expectation that the child replace relatives who were lost.[21]

The fact that one is a survivor's child does not guarantee that psychological problems or maladjustment will develop, just as being a survivor does not guarantee that psychological problems will ensue. But a large percentage of children of Holocaust survivors manifest Holocaust-derived behaviors, particularly on the anniversaries of their parents' trauma.[22] Many experience guilt, anxiety, and preoccupation with events that occurred to their parents, and the need to provide meaning for their parents' lives through their interaction with and accomplishments in the external world.[23] Some have post-traumatic symptoms such as abnormal fear of real or imagined dangers and mistrust of strangers.[24]

Children whose parents were the targets of more recent traumatic human rights abuses exhibit similar problems. Some were traumatized when they witnessed part of their parents' trauma. Many were uprooted; suffered loss of economic status, social stigma, or the destruction of their previous support system; or live with a care giver who is distressed and has inadequate emotional resources to fulfill their needs.

In one study, 85 children living in Denmark whose parents were tortured in Chile were followed clinically for as long as six years. The following symptoms persisted much of the time:[25] in descending order, between 59 percent and 16 percent of the children suffered from anxiety, insomnia, nightmares, "behavior difficulties," introversion, noctural enuresis, anorexia, headache, stomachache, diurnal enuresis, and difficulty with concentration. Increased symptoms were associated with age over six and the length of parental separation.

Another study looked at 28 children of Argentine refugee parents living in Mexico.[26] Half were separated from their parents, and in one fourth of the cases one parent was still missing. Half of the children witnessed the destruction of their homes and the beating of one or both parents. These children suffered from insomnia, eating disorders, behavioral regression, aggressiveness, and somatic complaints. Sleep, eating disorders, somatization, and regression tended to improve with time. Aggressiveness worsened, and dependence and regression appeared as new symptoms. The most persistent symptoms were dependency and aggressiveness. In a similar study of Chilean refugee children living in Canada, sequelae included behavioral and affective changes, social withdrawal, depression, fear, anxiety, and irritability.[27]

Children examined in the countries where their parents' human rights were violated react similarly to those living as refugees in other countries. While these children have not had to adapt to life in a new country, they experience the stresses associated with living in a country where human rights violations take place. Of 203 children examined at a mental health clinic in Chile whose parents had been detained or disappeared, 78 percent suffered from withdrawal, 70 percent had depression, and 70 percent had intense generalized fear triggered by specific environmental stimuli; 50 percent had a loss of appetite, weight loss, sleep disturbance, and regression in behavior, school performance, dependency, and crying.[28]

Philippine researcher Elizabeth Protacio-Marcelino described three stages of stress-coping in children of male political prisoners in the Philippines.[29] These stages are generally applicable to situations where a parent is detained. The first begins when a parent is arrested. It is a time of extreme emotional stress, fear, and anxiety accompanied by uncertainty about the future, confusion over events, loss of control, and helplessness. Common behaviors include seeking explanations about what occurred and what will happen and attempts to locate and visit the parent.

The second stage is one of adjustment. Because a parent is absent, the internal dynamics of the family and the roles of family members change. Often the children must adjust to changed economic circumstances or a new house, neighborhood, or school; the moodiness and changing temperaments of their parents; boredom when visiting the detained parent; and a mixture of joy, sadness, and bewilderment when political prisoners other than the parent are released. Because these are new experiences, the children have few coping alternatives; the coping devices they choose tend to be maladaptive and aggravate emotional distress.

The third stage is characterized by vigorous attempts to secure the detained parent's release. The stresses experienced by the children are essentially the same as in the second stage, but because they have adjusted to the situation, they have a wider latitude of coping alternatives. The children's greatest stress is associated with the frustration they feel when attempts to press for the detained parent's release are ignored or rejected by the government. As Protacio-Marcelino writes:

> *[G]iving a satisfactory explanation to the fact of detention to children whose perspectives in life have not yet been warped by the inequities and injustices around them is always difficult to do to a point that they can fully comprehend. And in the final analysis, there can really be no convincing answer because the continued detention of political prisoners is . . . unjust . . . .*[30]

PROGNOSIS AND TREATMENT

Certain behaviors and information help children cope with the stress of trauma. These include true explanations about the fate of parents in response to questions, successful individual or collective attempts to solve problems caused by the traumatic event, and secure and continuous child care.

Children may be buffered against further adverse effects of trauma by knowledge of the political beliefs of their parents; success in coping with past trauma; emotional support from family and friends; political, emotional, and material support from human rights groups; and play with children who have had similar experiences. Counterproductive coping mechanisms include avoidance, denial and other forms of inaction, and acting out or aggressive behavior.

Negative prognostic factors include young age; longer duration of exposure or repeated trauma; family and social isolation; inadequate or untrue explanations of what happened; poor physical health; worsened economic circumstances; loss of a dominant parent; parental activities and emotions that result in neglect of the child; unsupportive relatives, classmates, or friends; and care givers' insufficient knowledge or divergent opinions on childcare. Researchers who have worked with children traumatized in the United States have observed that the intensity of the exposure to trauma is an indicator of post-traumatic sequelae.[31] They also have found that post-traumatic sequelae are greater if the relationship between the victim and the child was close.[32]

Treatment must be related to the child's developmental stage and perception of the trauma. Factors such as loss, grieving, guilt, stigma, nightmares, and changes in behavior must be addressed. Internal motivation and emotional strengths must be reinforced. When treating adults who were traumatized as children, be alert to the possibility that the survivor's perception of his or her trauma has not been altered by maturation, and that the adult survivor may harbor thoughts and feelings relating to the trauma that are expected in a child but not in an adult. In these cases the survivor must be helped to reexamine the trauma from an adult perspective.

Treatment methods must be appropriate to the survivor's age. Among methods that have been used are directed and undirected drawings, a trauma-specific coloring book coupled with discussions about it, informational booklets for children or their parents, group therapy, and efforts to obtain release of or information about the relative.[33] Treatment may also involve psychotherapeutically-oriented play therapy with an emphasis on reality testing, attempts to increase frustration tolerance, encouragement of verbalization as an alternative to physical reenactment, and encouragement of repression instead of denial, projection, or dissociation.[34] In children of traumatized parents, the untangling of their experiences from those of their parents must be accomplished.

Other helpful therapeutic techniques include family therapy that focuses on strengthening the resources and coping mechanisms of the family using cognitive or other therapeutic methods, group activities that help to create new bonds of friendship, and education of parents in child care and post-traumatic sequelae. Whenever possible, refer the family to services that can help them restore their living and material conditions to approximate the pre-traumatic period.

Successful interventions with child survivors and children of survivors can both alleviate post-traumatic sequelae and prevent their transmission from one generation to the next.

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frequently do most of the parenting because the father is absent or unable to assume a traditional paternal role because of irritability, poor physical health, or fatigue. Veterans who witnessed the killing or maiming of children tend to be overprotective or overdemanding of their children. Children in these families have been noted to have depression, behavioral problems, and problems at school. The length of the father's absence has been related to the degree of his childrens' psychopathology. Segal, Julius; Hunter, Edna J.; Segal, Zelda, (1976) Universal Consequences of Captivity: Stress Reactions among Divergent Populations of Prisoners of War and Their Families, *Am Soc Sci J* 28: 593-609.

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11. Prevention

The most tragic aspect of working with survivors of traumatic human rights abuses is that their trauma and suffering could have been prevented. Although this book has focused on ways to help survivors once torture or other abuses have occurred, the greatest need is to prevent such abuses from occurring at all.

Prevention takes three forms: primary prevention aimed at preventing the torture or other traumatic event from occurring, secondary prevention directed at early intervention before the impact of traumatic sequelae has occurred, and tertiary prevention aimed at reducing post-traumatic sequelae once those sequelae are present.

PRIMARY PREVENTION

Primary prevention is the most difficult for North American health professionals because it involves political activism which most North American health professionals think of as distinct from the provision of health care.[1] Health professionals living outside of countries where traumatic human rights abuses occur commonly regard them as distant events over which they can have no influence. Yet becoming involved in the prevention of traumatic human rights abuses is a vitally important public health activity.

Governments that violate the rights of their citizens may be powerful but they are not omnipotent. In the face of sufficient domestic and international criticism, protest, or sanctions, they must relent or they will crumble. You can pressure such governments in many effective ways. You can participate in campaigns initiated by national and international human rights and medical or scientific organizations aimed at stopping rights abuses or make financial contributions to such organizations to support their work.

International human rights organizations such as Amnesty International and Human Rights Watch periodically publicize the cases of persons who are persecuted because of their political opposition or outspoken criticism of torture, political killing, or other violations of internationally recognized human rights. They call on individuals to send letters or telegrams to the authorities of the country concerned demanding that mistreatment cease and that the person be accorded

APPENDIX G

The Psychiatric Effects of Massive Trauma on Cambodian Children:

I. The Children

J. DAVID KINZIE, M.D., WILLIAM H. SACK, M.D., RICHARD H. ANGELL, M.D., SPERO MANSON, PH.D., AND BEN RATH

This report, which uses standardized interviews by psychiatrists, describes the psychiatric effects on 40 Cambodian high school students in the United States who suffered massive trauma from 1975 to 1979. They endured separation from family, forced labor and starvation, and witnessed many deaths because of the Pol Pot regime. After 2 years of living in refugee camps, they immigrated to the United States at about age 14. Four years after leaving Cambodia, 20 (50%) developed posttraumatic stress disorder; mild, but prolonged depressive symptoms were also common. Psychiatric effects were more common and more severe when the students did not reside with a family member.

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Since the studies of the Nazi concentration camp victims after World War II it has been known that massive trauma causes serious and long-term psychiatric effects (Chadoff, 1975; Eitinger, 1961). Such trauma has often fostered a unique group of symptoms referred to as the concentration camp syndrome. Most of the symptoms are similar to those included under the posttraumatic stress disorder (PTSD) diagnosis of DSM-III. Studies indicate, however, that concentration camp experiences affect not only prisoners but their families as well; the symptoms are long-lasting and often resistive to traditional psychotherapy treatment.

Psychological or behavioral effects of traumatic experiences on children and adolescents followed a cyclone disaster (Milne, 1977), a severe winter storm (Burke et al., 1982), and the Buffalo Creek flood (Newman, 1976). Terr's (1983) work with school bus kidnapping victims indicated multiple posttraumatic symptoms were present even 4 years after the incident. The effects of war on children noted by A. Freud and Burlingham (1943) during World War II and others during Middle East conflicts (Milgram and Milgram, 1976; Ziv and Isreali, 1973) indicated that increased anxiety was inconsistent, and was probably modified by the presence of adults and other factors.

A few clinicians have reported on the effects of massive psychic trauma of a concentration camp on children (Krystal, 1978; Sterba, 1949). When such massive trauma has occurred in Southeast Asian refugee children, a group already vulnerable to stress and psychiatric disorder (Tobin and Friedman, 1984; Williams and Westermeyer, 1983), significant psychological and behavioral disturbances have not been unexpected.

This report describes adolescent children who lived through 4 years of severe concentration camp-like experiences in Cambodia from 1975 to 1979. The 40 students studied are compared to 6 Cambodian students who escaped internment. We will further describe the psychiatric disorders among the affected group and relate them to both the traumatic experience itself and posttraumatic and immigration experiences.

To our knowledge this is the first report, using operationally defined diagnostic criteria of mental disorders, of the psychiatric effects of massive trauma on children.

Background

One of the more tragic outcomes of the Indochinese conflict was the takeover of Cambodia in 1975 by the Pol Pot radical Marxist regime. By following a strict simplistic communist philosophy there was an attempt to divest Cambodia of any western or urban influence and return it to an agrarian communal society. As a result, city people were sent to work camps throughout the country. Families were separated and most children and adolescent children were put into

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camps according to age groups with little or no contact with their parents. Adults with western education and western influence or contact, as well as government officials, military officials, and Buddhist monks, were executed. As a result of mismanagement thousands died of starvation or famine. It is estimated that, through deaths by execution, starvation, and disease, one-third to one-fourth of Cambodia's 7 million population perished in 4 years of nightmare (Hawk, 1982). It ended only in 1979 when the Vietnamese invaded Cambodia. Subsequently many Cambodians were able to escape as refugees to Thailand and, later, a smaller group came to the United States.

For 6 years the Department of Psychiatry of the Oregon Health Sciences University has sponsored an Indochinese refugee clinic (Kinzie and Manson, 1983). Recently the clinic staff became aware of the severe difficulties adult patients were having as a result of their Pol Pot experiences. We ultimately identified the PTSD among these patients (Kinzie et al., 1984). This report adds a nonclinical population of high school students originally from Cambodia who also endured 4 years of this massive trauma.

Method

Teachers in an Oregon high school became concerned about the unusual behavior of some Cambodian refugee students, noticing startle reactions and at times the pressure of the students to tell horrible events of their past. When teachers approached our department about these observations, a research project was organized involving 3 members of our department, a Cambodian mental health worker, and teachers and counselors at the school. The school, having 52 Cambodian students, offered an opportunity to interview these students and to obtain home and classroom observations on their behavior. The interviews were done by one psychiatrist (J. D. K.), who has worked with Southeast Asians for 6 years, and two child psychiatrists (W. S. and R. A.) from the department of psychiatry. All interviews were done in the presence of a trained Cambodian mental health worker (B. R.) who had American university experience and 5 years of training in American mental health and psychiatric clinics.

The semistructured interviews included specific questions related to current family life, health, school experience, life in Cambodia before Pol Pot, the experiences during Pol Pot, the refugee camp experiences and life in the United States. This inquiry was guided in part by Terr's (1979) work on psychic trauma.

From the Schedule of Affective Disorder and Schizophrenia (SADS) (Spitzer and Endicott, 1979) specific questions were asked on affective disorder, panic disorder, phobia, and anxiety. These led to a Research Diagnostic Criteria (RDC) diagnosis of these respective disorders. PTSD questions from the Diagnostic Interview Schedule (DIS) led to a DSM-III diagnosis of PTSD (Robbins et al., 1982). Mental status examinations included orientation, calculation, and recall. Any leads from the questions and any ambiguities or nonverbal reactions were noted and followed up during the interview. An original interview was taped by one psychiatrist (J. D. K.) and observed and discussed by the other two psychiatrists (W. S. and R. A.) to ensure a standardized approach to the interviews. With the presence of the same Cambodian mental health interpreter in all interviews, further standardization was assured. After each interview a narrative psychiatric history was dictated.

After each psychiatrist had completed several cases, each case was presented by the interviewer and discussed in detail to ensure feedback on the approaches and standardization. At this time the Childhood Global Assessment Scale Score (CGAS) (Shaffer et al., 1983) was assigned by the interviewers. Subsequently the primary interviewer gave a diagnosis on a basis of RDC criteria. Each protocol was also evaluated independently by a second evaluator. The interrater reliability of the diagnosis of PTSD was 85%; and the presence of depressive disorder, 88%.

All students participating in the interview heard the purpose of the interview explained in both English and Cambodian; they signed a written consent form as did their legal guardians. The interviews were usually done about half in English and half in Cambodian, but varied from 100% English to 100% Cambodian. The interviews often were emotionally charged for the student, interpreter, and psychiatrist, as the questions involved memories of severe trauma and losses. Nevertheless, 46 of the school's total of 52 Cambodian students agreed to participate in the project.

Results

Life Experiences and Effect of Pol Pot Regime on the Students

Six of the 46 refugees interviewed escaped the Pol Pot experience—they either came to the United States in 1975 or were in another country during that time. These 6 (2 males and 4 females) with an average age of 17 years, who served as "normal" refugees, although not considered as an adequate control group, has been in Oregon an average of 45 months. All lived with some family members, but 3 were separated from their parents. They reported very few symptoms; no diagnoses were made. Their average childhood global assessment rating was 84 with a range of 75–92. In general, they were performing in the good to superior

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range of functioning and by all accounts were adjusting well to American culture.

The other 40 students lived 4 years under the Pol Pot regime in Cambodia and comprised the focus for this paper. These students all were raised, until Pol Pot, in traditional Cambodian homes emphasizing the cultural values of a strong family identity, respect for ancestors and the past, a need for smooth interpersonal relationships (nonconfrontation in cases of disagreement), tolerance for ambiguity, and willingness to accept things the way they are. Traditionally, high status was accorded to scholars. The predominant faith was Buddhism and with a belief in reincarnation. Current success or failure depended upon deeds done in a previous life. The Pol Pot's ideology struck at the heart of traditional Cambodian beliefs, especially their respect for family, the past, and the Buddhist religion.

The 40 students included 25 males and 15 females, with an average age of 17 and a range of ages of 14-20. Three females and 5 males had not yet reached puberty. In Cambodia, their fathers were generally employed in the military, government or business, or were farmers. Twenty-eight of these lived in cities, while the others lived in rural areas. Thirty-one went to school in Cambodia and 33 could read Cambodian. Only 4 spoke English when they came to the United States. Currently 11 were living with their natural fathers, 20 with their natural mothers and 15 had some siblings. Overall, 26 were living with some family members while 14 were living in either American or Cambodian foster homes or alone.

The "average" childhood experience could be described as follows (Table 1): Born in a Cambodian city in 1967; began school in 1973; terminated schooling abruptly in 1975 (not to be resumed until reaching the United States); endured 4 years of the Pol Pot concentration camp experience from 1975 to 1979; escaped to Thailand and became refugees for about 27 months. The students came to the United States in 1982 and had been in this country (attending high school) an average of 2 years.

The shared traumatic experiences of the 40 students are summarized in Table 2. Thirty-six lived entirely in age-related segregated camps for the 4-year period. Thirty-three were separated from their families during that time. Almost all (39) endured forced labor—often 15 hours a day, 7 days a week. Thirty-three went without adequate food for long periods and 27 starved to the point where they described themselves as "looking like a skeleton"; 17 had edema in their legs. Seventeen students saw people killed and 7 saw their own family members killed. Fifteen described themselves or their families as being beaten. All had seen corpses. Twenty-seven had members of their group killed while trying to escape to Thailand and 20 still felt their life was in danger in Thailand.

The number of "lost," killed, or missing family members of this group was extremely high. Eighteen of the 40 knew their fathers had died; 7 knew their fathers were missing (63% without fathers). Eleven mothers were dead and 4 were missing (38% without mothers). Sixteen had at least 1 sister and 15 at least 1 brother dead or missing. Thirty-two of the 40 (80%) lost at least 1 family member; the average number lost, either dead or missing, was 3 members of the nuclear family.

Symptoms

Although the interview was primarily designed to identify a psychiatric diagnosis, the major symptom patterns are of interest (Table 3). Twenty-six of the students reported headaches and 15 had some concern about their health. Other health symptoms, however, were not reported to a large extent. The major symptoms of posttraumatic stress as reported by a large number of students included nightmares, recurring dreams, being easily startled, feeling ashamed of being alive (intrusive mental states) and avoiding memories of Cambodia or completely avoiding discussion of the traumatic events (avoidance behavior).

Trouble sleeping and trouble concentrating are posttraumatic and depressive disorders. Additionally, there were a number of depressive symptoms reported, including some appetite or weight changes, loss of energy and interest, a sense of feeling guilty, a pessimistic outlook, and brooding. A number of the students felt inadequate and resentful, and expressed self-pity. Only 6 reported suicidal thoughts. Eight students described some type of panic attacks, but only a few described the whole symptom complex of panic disorder. Generalized anxiety also occurred in a small number of students.

TABLE 1

"Average" Life Experiences of 40 Cambodian Students

Year	1967	1973	1975	1979	1982	1984
Age	0 Early family life in Cambodian city	6 2 years of school	8 4 years of Pol Pot "concentration camp"	12 Refugee in Thailand	15 in United States	17 Present study

TABLE 2

Four Years of Pol Pot "Work Camp" Experience (N = 40)

N	Percent	Experiences
36	90	Lived in age-segregated camps
33	83	Separated from family
39	98	Endured forced labor—often 15 hours a day, 7 days a week
33	83	Went without enough food for long time
27	68	Described themselves as "looking like skeleton"
17	43	Described swelling in legs (edema)
17	43	Saw people killed
7	18	Saw family members killed
15	38	Described themselves or family beaten; all saw corpses
27	68	Had members of their group escaping to Thailand killed
20	50	Felt life still endangered in Thailand

TABLE 3

Current Major Symptoms (N = 40)

N	Percent	Symptom
		Health
26	65	Headaches
15	38	Concerned about health
		PTSD Symptoms
22	55	Nightmares
20	50	Recurring dreams
20	50	Easily startled
28	70	Felt ashamed of being alive
23	58	Avoided memories of Cambodia
17	43	Never discussed Cambodian events before
		PTSD and Depressive Symptoms
22	55	Trouble concentrating
16	40	Trouble sleeping
17	43	Appetite or weight change
		Depressive Symptoms
21	53	Loss of energy
19	48	Loss of interest
19	48	Feeling guilty
17	43	Pessimistic outlook
17	43	Brooding
21	53	Feeling inadequate
22	55	Feeling resentful
24	60	Self-pity
14	35	Restless, unable to sit still
6	15	Suicidal thoughts
14	35	Feeling depressed some of time over 2 years
		Other
8	20	Described some type of panic attacks; few described specific panic symptoms

TABLE 4

Current Diagnosis by RDC Criteria (N = 40)

N	Percent	
20	50	PostTraumtic Stress Disorder (DSM-III)
21	53	Depressive Disorder, all types 5 Major Depressive Disorder 1 Minor Depressive Disorder 15 Intermittent Depressive Disorder
		17 of 20 PTSD also had a depressive diagnosis
3	8	Panic disorder
7	18	Generalized anxiety disorder
		27 had at least one diagnosis
No cases of schizophrenia, drug or alcohol abuse, antisocial or conduct disorders		
Others		2 mild mental retardation 1 Organic brain syndrome with oppositional personality disorder 1 schizoid personality
Medical		2 blindness of one eye (one also amputation of arm) 6 inactive tuberculosis 1 unknown atrophy of leg

Diagnosis

By DSM-III criteria 20 students met the diagnosis for current PTSD (Table 4) and 5 met the diagnosis for major depressive disorder (RDC). (An additional 5 would have made the latter diagnosis but the duration of 2 weeks was not met.) One met the diagnosis of minor depressive disorder, and 15 met the diagnosis of intermittent depressive disorder—that is, they had some depressive symptoms much of the time for 2 years. Additional students suffered from a major depressive disorder but because of poor recall or difficulty in recalling the duration did not technically meet the criteria.

We were impressed that depressive symptoms from a mild to moderate degree were quite common in this group. Overall, 21 students met some diagnosis for depressive disorder. Depressive disorder and posttraumatic stress are closely related and 17 of the 20 persons with posttraumatic stress also had a depressive disorder. Three met the diagnosis for panic disorder, and 7 for anxiety disorder. Twenty-seven students had at least 1 diagnosis while 13 had none. Significantly, no case of schizophrenia, drug or alcohol abuse or antisocial conduct was found. Other diagnoses included mild mental retardation (2 students), organic brain syndrome plus an oppositional personality disorder (1 student), and schizoid personality of adolescence (1 student). Medical problems in this group included inactive tuberculosis (6 students). Two people, 1 with an amputation of the left arm as a result of a traumatic injury, were blind in 1 eye; both had stepped on mines while escaping to Thailand.

Childhood Global Assessment Scale

Compared with the 6 "normal" Cambodian refugees whose average CGAS score was 84, the CGAS average score of the 40 students who lived under Pol Pot was 62 with a range of 43–75. Ten, or 25%, of the 40 students who lived under Pol Pot had a score higher than 71, which equals no more than slightly impaired functioning. Twelve, or 30%, rated some difficulty in a single area but generally were functioning well—they had a score of 61–70. Thirty-five percent, or 14,

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scored 51–60 either with variable functioning with sporadic difficulties or with symptoms in several but not all social areas. Four, or 10%, scored below 50 and had a moderate degree of interference in most social areas or severe impairment in a single area. In no case did the Pol Pot students score higher than the non-Pol Pot Cambodian refugees (Table 5). Since the childhood global assessments were made by the same psychiatrists who did the interviews and were partly based upon symptoms, it is not surprising that the CGAS score strongly related to the current diagnosis as shown in Table 6.

In other words, the presence of a psychiatric diagnosis related at a significant level with receiving a lower CGAS score.

Correlates of Receiving a Psychiatric Diagnosis or a Low CGAS Score

Not all of the 40 students received a psychiatric diagnosis, although all experienced a significant amount of trauma over a prolonged period of time. We found no relationship between the experience in Cambodia, age and sex and the presence or absence of a diagnosis. There also was no simple or direct relationship with specific reported experiences in Cambodia such as the death of family members, seeing killings, being beaten, going without food, having leg swelling, or starved to the point of looking like a skeleton. Also, none of these factors related to receiving a lower CGAS score.

However, there was a strong relationship between the current living situation and a psychiatric diagnosis. This is shown in Table 7. Twenty-six of the 40 lived with 1 or more nuclear family members, while 14 lived in a Cambodian or American foster home, or alone. (Thirteen of the 14 received a psychiatric diagnosis while only 12 of 26 living with a nuclear family member received a diagnosis.) The nuclear family members could be any combination of a natural father, a natural mother, or siblings. Similarly, as shown in Table 8, there was a strong relationship between the CGAS and not living with nuclear family members. One-way analysis of variance on the means of these scores shows this relationship. In other words, although diagnosis of a disorder and low CGAS scores are common, it is more common to have a diagnosis or lower CGAS score in those students who live in a foster family or alone.

Discussion

At an early age these young Cambodian refugees of our report were separated from their families for 4 years, endured forced labor and starvation, and watched many deaths, in some cases of their own family members. Their traditional cultural values and belief systems were discredited or destroyed. They spent 2 more years in a refugee camp and then began high school in a foreign country without knowing the

TABLE 5

Childhood Global Assessment Scores (N = 40)

Score[a]	Assessment	*N*	Percent
71	No more than slight impairment in functioning	10	25
61–70	Some difficulty in single area but generally functioning well	12	30
51–60	Variable functioning with sporadic difficulties or symptoms in several but not all social areas	14	35
50	Moderate degree of interference in most social areas or severe impairment in a single area	4	10

[a] Mean = 62; range = 43–75; "normal" Cambodian refugee average CGA = 84.

TABLE 6

CGA Score Strongly Related to Current Psychiatric Diagnosis[a]

Score	Presence of Diagnosis	
	No	Yes
71	7	3
61–70	5	7
51–60	1	13
50	0	4
Total	13	27

[a] Corrected χ^2 test, $df = 3$, $p < 0.0049$.

TABLE 7

Presence of Current Psychiatric Diagnosis Strongly Related to Living without Any Family Members[a]

Home Life	Presence of Diagnosis		Total
	No	Yes	
Live with a nuclear family member[b]	12	14	26
Live in Cambodian or American foster family or alone	1	13	14

[a] χ^2 test $df = 1$, $p < 0.0309$.

[b] The relationship holds if natural father, natural mother, or siblings in home.

TABLE 8

CGA Scores Related to Living without Any Nuclear Family Membe

Home Life	CGA Score (Mean
Live with member nuclear family[a] (*N* = 26)	64.6
Live with foster family or alone (*N* = 14)	56.3
One-way analysis of variance $p < 0.0095$	

[a] The relationship holds true if father, mother or sibling is in home.

language and often without family. Even 4 years later, after leaving the most severe of the traumatic experiences behind, half of the 40 students still experienced major symptoms considered as PTSD. Twenty-one students also had symptoms of an on-going depressive disorder. Although usually mild, the disorder was present some of the time with some symptoms for 2 years or more. Both of these diagnoses represented enduring profound effects of this experience.

Additionally, the group in general had low scores on the CGAS, corresponding to some degree of impairment and functioning, especially compared to the other Cambodian students. No student told of or by other evidence was described as having social acting-out behavior, truancy, or other disruptive behavior in school, a significant finding. Neither alcohol nor other drug abuse was reported in this group. In general, their symptoms were private, subjective, and characterized by denial and avoidance of thinking about their problems or their symptoms. American adolescents experiencing trauma or stress are stereotyped as acting out in antisocial or drug-seeking behavior. This is exactly opposite of what the Cambodian students demonstrated. Their problems were internal and much of their behavior and thought served to avoid or deny the significance of their past.

Of particular interest is that the amount of trauma per se, or the experience in Pol Pot Cambodia as reported by the students, by age or sex, were not related to the current diagnosis or global functioning. However, not living with a nuclear family member predicted the diagnosis of a major illness as well as lower global assessment scores. Indeed, 13 out of 14 people living in foster homes or alone had a psychiatric diagnosis. Although the students in general had lost members of their family, averaging 3 members of the nuclear family, those who had been able to reestablish family contact with any family member and live with them did much better than those without some contact. It may be that those without any family contact—that is, they lost their entire family—had more trauma. But it seems more likely that having reestablished some contact with family members in this setting mitigated some of the symptoms of the severe trauma, while being alone or in a foster family exacerbated the disorder. The role of the family continued to be extremely important in modifying these disruptive symptoms (see Part II; Sack et al. (1986)).

Although our rates of psychiatric disorders were high, not every student had a diagnosis or was severely impaired by the profoundly disturbing trauma. Indeed the lack of more social impairment or antisocial behavior in this group was remarkable. Although some of the successful coping and adjustment was obviously due to the presence of a family member, other factors must be taken into consideration. The traditional Cambodian and Buddhist values of acceptance of one's life, the importance of education, and the belief that present events are influenced by past actions may have helped shape a coping style characterized by suppression of feelings and avoidant behavior. This was indicated by the students' frequent denial of distress and their avoidance of memories or events which would remind them of past events. This avoidant behavior seemed to minimize symptoms and the social consequences of the symptoms. Avoiding intrusive thoughts and memories perhaps balances the distress that they feel.

To the extent that this mechanism has prevented socially disruptive behavior, symptom formation, or poor school performance, it has been successful. However, it has also left many students somewhat isolated and with subjective suffering. Such traditional Cambodian values as passive acceptance may provide a more useful means of coping with this disorder than western values which emphasize talking about the problem and expecting or excusing disruptive behavior because of the trauma. The lack of school disruption may also have both cultural and immediate determinants. School is viewed positively by the students, perhaps because of the traditional Cambodian value placed upon the status of the scholar. Also, at least in this setting, school is a secure place of acceptance and social interaction (see Part II; Sack et al. (1986)).

The Pol Pot regime attempted to destroy the roots of the Cambodian past and values. However, these same values may have helped the students to cope with the brutality of Pol Pot. Further long-term studies are needed to determine whether these mechanisms will continue to be effective or whether in the future there will be further disruption or symptom formation at other times of stress.

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The Psychiatric Effects of Massive Trauma on Cambodian Children:

II. The Family, the Home, and the School

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Forty Cambodian high school students who survived 4 years under the Pol Pot regime (1975–1979) and 6 Cambodian students who escaped their homeland prior to Pol Pot were studied by means of home interviews and school teacher ratings. In these findings, compared to psychiatric interview data on the same subjects, students reported more distress with school grades, peers and themselves than was observed by their caretakers. Many of their family members exhibited similar posttraumatic stress and depressive symptoms. In school, students receiving a psychiatric diagnosis were more likely to be rated by their classroom teachers as withdrawn or daydreaming than as disruptive. The crucial role of the school as a cultural agent of change became strongly evident.

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In Part I of our study of Cambodian adolescent refugees (Kinzie et al., 1986), we described the psychiatric status of these students, obtained from a standardized semistructured clinical interview. In this report we present findings on the families of these students, obtained from a home interview, and on their school performance and adjustment, obtained from teacher ratings and school records.

The extreme suffering these students endured as children under the Pol Pot regime in Cambodia (1975–1979) could not be isolated from that of family members. After the horrors of Pol Pot, when the entire traditional fabric of family life was targeted for destruction, Cambodians felt new uncertainty about family survivors, and apprehension about migration to a strange land. The accumulated stress on families was therefore enormous.

The role of the family has long been recognized as an important variable in the adaptation of children during disasters. A. Freud and Burlingham (1942) found, for example, that in World War II maternal reactions had more of an effect on children than the children's own reactions to the bombings per se. Burke et al. (1982), in their investigation of the effects of a natural disaster, found that the parents' denial resulted in their minimizing their children's distress. Aleksandrowicz (1973) described an "affective deficiency syndrome" with associated hyper-repression in a study of 34 Holocaust families. Other authors (Daniele, 1980; Freyburg, 1980) focused on survivor parents' tendency to create family relationships characterized by extreme cohesion and loyalty. As a result of their own fears of separation, these parents became overly protective and blurred boundaries between themselves and their children. Adolescents in such families were thought to have special difficulty when their strivings for independence and autonomy came into conflict with their parents' desire to keep the family intact. They subsequently manifested this conflict by disruptive and antisocial behavior. Zlotogorski's (1983) investigations of holocaust families did not, however, support this inevitable portrayal of extreme cohesiveness and disturbed affective communication. He found instead a wide variation of family functioning often quite similar to the control families. As described in Part I of this study, family relationships served well as buffers against the massive trauma suffered earlier in Cambodia. Those living with family members did better than those without a natural family. The school also played a crucial, multifaceted role in aiding accommodation to a new country, a new language, and new cultural demands.

In compiling our data, compared with self-reports from the psychiatric interview (Kinzie et al., 1986), we relied on home interviews of the students and on family observations. The school inquiry followed much

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the same format: teacher ratings of classroom performance and behavior, plus the school records.

Method

The semistructured psychiatric interview, the Children's Global Assessment Scale (CGAS) (Shaffer et al., 1983), and the consent form have been described (Kinzie et al., 1986). The structured interview for the home study consisted of 110 items, plus a 25-item home observation inventory, and was administered by a trained Cambodian mental health professional (B. R.) to a natural or foster parent. The family questionnaire covered the student's health, the parents' assessment of the student's school and social functioning, and family relationships, rules of behavior, and finances. The parents were asked about the possible presence of postraumatic stress disorder (PTSD) and depressive symptoms. A multiplicity of observations were made about family configuration, fluency in English and social class status, the physical characteristics of the home, and an estimate of acculturation.

The information obtained from the cooperating Oregon high school came from three main sources: (1) a classroom teacher checklist (already in use by the school), (2) global ratings by two English-as-a-second-language (ESL) teachers, and (3) official school records. Items pertaining to the PTSD were added. The checklist was divided into two main sections: academic ratings and behavior ratings. Each student received at least two ratings by two different teachers at various times from January to June 1984. In analyzing this information, scores from these two ratings were averaged.

These global academic assessments were designed to gain an overall impression of each student's academic skills, motivation to learn, and sociability in school. Two ESL instructors who had personal knowledge of these students rated each separately at the end of the term, June 1984. Their interrater reliability was 91%.

Even though the psychiatric interviews were conducted in the school, the teachers were "blind" to the psychiatric assessments until after the study. The psychiatrists were also blind to the teacher ratings and home interviews throughout the data collection which ran from January to June 1984.

The formal school record yielded days absent, a record of any disciplinary incidents, grades, and achievement test results. These data were then used in making two-way comparisons against psychiatric assessment ratings, using the chi square (χ^2) test. The study was an overall exploration into the many psychosocial and psychoeducational variables of these students. Because of the small sample size, findings of statistically significant differences were interpreted as tentative. For the sake of brevity, the two-way comparisons will be presented with their χ^2 values and p value in parentheses.

Results of Home Assessment

Family Characteristics

Twenty-six of the 40 "Pol Pot" students were in homes of members of the nuclear family, that is, with parents or siblings. The remainder were in foster homes or, in the case of one, living alone. Ten students' foster parents were Cambodian and four were American. A wide variety of family configuration was found ranging from two-parent to all-sibling families. Physically the homes were crowded by Western standards (as many as 12 people lived in one home). Two-thirds of the families lived in apartments. In all the non-American homes, the language spoken was Cambodian (Khmer).

Over one-half of the families received public assistance, and only about one-third included a parent who was steadily employed. Most families were living either at a poverty or working-class level. Three-quarters of the adults interviewed felt that their financial assistance was inadequate. A third of the students earned extra money by part-time jobs.

In appearance, homes of 32 of the students blended Cambodian and American cultures; statues, pictures, baskets, evidence of Buddhist religious practice, and other ethnic possessions were observed along with American furnishings. All but one home had a television. In all of the Cambodian homes, even those that appeared more American, interest in Cambodian culture seemed high.

It was difficult to assess the degree of marital and family discord in these homes given the Cambodian's concern about propriety. Basing his impressions on observations of disagreements and nonverbal interactions, the interviewer found that two-thirds of the parents got along well with each other and of these, half got along very well. No overt marital discord was seen.

Relationships between siblings were also described with only 4 of the 40 subjects reporting difficulties.

Almost all homes had rules about curfew time, choice of friends and activities, and watching TV. The parents, furthermore, thought that these rules were well tolerated by their children. All but four of the parents thought they got along well with their children and the majority of the parents reported they enjoyed the time spent with their children.

We found no significant association comparing family variables with economic status. Foster children lived in homes with a much higher economic status than in the homes of those students living with their own family ($\chi^2 = 8.23, p = 0.0060$). However, students in foster homes had a much higher rate of psychiatric diagnosis (Kinzie et al., 1986).

Parents' Symptoms

We found that more than three-quarters of all the parents had lived in Cambodia under Pol Pot. This high percentage included both Cambodian foster parents and natural parents.

When we inquired about the level of stress parents were experiencing, we found that more than one-half of the respondents had the following symptoms (sometimes or often): trouble sleeping, trouble concentrating, anxiety, fatigue, irritability, and sad or "feeling blue." Two-thirds of the parents who admitted to four or more of these symptoms had lived through the Pol Pot years.

Comparisons between Parent and Student Observations

Numerous comparisons were run on multiple variables in an attempt to find patterns of consistency from the two sources of information, the home interviews and the clinical interview. We compared the students' symptoms with the parents' report of these same symptoms. Comparisons of a psychiatric diagnosis and parental perceptions were also done. Likewise, the parents' reports of their child's school functioning were compared with students' reports and grade point average. None of these yielded statistically significant relationships.

When asked how parents thought their children got along with their peers, only four were thought to have difficulty. However, in our interview one-half of the students reported that they did not have many friends.

The parents of all but one of the students said that they had talked with the student about their experiences during the Pol Pot regime. But when we asked students this same question, the answer differed: less than 50% said they had discussed Pol Pot with their parents. We also wanted to know whether having a more symptomatic parent predisposed the students to be more symptomatic. There was no significant association between either the number or type of symptom reported by the parent and the student. The students were not unaware of their parents' symptoms. For instance, in the semistructured interview we found that a student would occasionally initially deny having a symptom himself, but would identify another person in the home who was having this particular symptom. Later, he/she might admit to it as well. In summary, student self-reports and parent reports were not consistent. This is not surprising as Cambodians are taught to bear pain silently and not to burden others.

Results of the School Assessment

General Description

It is important to emphasize that this study could not have been undertaken without the active support of the ESL faculty and its school administration. Their concern for the psychological welfare of this group of students led to an initial request for assistance from the Department of Psychiatry, Oregon Health Sciences University. All subsequent phases of this project were carried out jointly with the participation and consent of the ESL staff. The student interviews, for instance, were all done at the school.

Most of these students were listed as sophomores or juniors in the school register. Their prior education had been severely disrupted: 50% had less than 3 years of schooling before entering the United States; only 6% had more than 4 years of schooling. Twenty-five percent had no schooling.

The teacher checklist was composed of both academic and behavioral questions. The number of students scoring "below average" or "having difficulty" on two or more of the academic items were tabulated. Likewise, those who scored deviantly on two or more behavioral items were also counted. We found that these students were more likely to be seen as behaviorally deviant (25%) than academically deviant (15%). This agreed with the teachers' overall assessment of these students as generally diligent and conscientious learners. For instance, only 7 of the 46 students were absent for more than 5 days during the school year. Only 9 disciplinary incidents, all minor and none involving drugs or alcohol, were logged in the school record during the year.

If rated as behaviorally deviant on the teacher checklist, they were more likely to be rated as withdrawn or daydreaming than disruptive. On the whole, these were not oppositional or rebellious students. Occasionally there would be flashes of hostility between the Cambodian and Vietnamese students (traditional cultural antagonists). The more specific symptoms of the PTSD (such as startle reactions or flashbacks), while dramatic examples of suffering, were not common classroom occurrences.

Ten of the 46 students received a Grade Point Average (GPA) for the 1983–1984 academic year of 2.0 or below. The pattern of school grades often took a noticeable decline as these students moved from the ESL program into the mainstream of the high school

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curriculum. Despite their hard effort, at the end of the 1983-1984 academic year, less than a quarter of the students could pass the high school graduation standards tests of Oregon high schools (a test comparable to roughly the 7th grade achievement in reading, language, and mathematics).

Comparisons between School Observations and Student Self-reports

As noted before, those 40 students who were Pol Pot survivors were more likely to receive one or more psychiatric diagnoses ($\chi^2 = 7.22$, $p = 0.007$) than the 6 "non-Pol Pot" students. Yet, when we compared these two groups on academic classroom measures or GPA averages, we found *no* significant differences. Likewise the Pol Pot group was not significantly absent more frequently, nor did they show significantly more disciplinary incidents than the non-Pol Pot students. However, when we compared these two groups on the teacher behavioral portion of the checklist, we did find some significant differences: the Pol Pot adolescents were more likely to be rated as deviant on two or more behavioral items than the non-Pol Pot group ($\chi^2 = 5.66$, $p = 0.01$).

When we compared the two groups on one particular item—being emotionally withdrawn—we also found a significant difference ($\chi^2 = 4.82$, $p = 0.02$). Other behavioral items did not by themselves yield significant differences.

Next, we examined *only* the 40 Pol Pot students and divided them into two groups: those who had received one or more psychiatric diagnoses, and those not receiving a psychiatric diagnosis. We then compared these two groups of students on the same school variables. Again, no differences were found in terms of the GPAs of either group or in the teacher's *academic* ratings between the 27 students who had received a diagnosis and the 13 who had not. When we compared these same groups against those who had received a deviant score on two or more teacher-rated *behavioral* items, we again found a significant difference ($\chi^2 = 6.41$, $p = 0.01$).

When the CGAS was used instead of psychiatric diagnosis, a similar difference was found. Dividing students into those who scored 60 and above versus those scoring below 60, we found the teacher's rating of behavioral deviance in the latter to be significantly related ($\chi^2 = 4.94$, $p = 0.026$). This time the particular behavior of being emotionally withdrawn in class, as well as daydreaming, also appeared related to the CGAS of below 60 ($\chi^2 = 6.71$, $p = 0.01$).

We had two independent teacher ratings of students' academic skills: those on the teacher checklist and those from the year-end global ratings of the two ESL teachers. There was a significant relationship between these two ratings ($\chi^2 = 8.54$, $p = 0.003$). There was also a strong relationship between the students' GPA score and the classroom teachers' rating on academic items ($\chi^2 = 4.95$, $p = 0.02$). These independent measures served as a validity check for the teacher assessments.

The global ratings of overall student sociability did not show a significant relationship with other academic or behavioral measures. In attempting to obtain some overall measure of these students' peer contacts and involvement, the ratings did show that most of the students maintained friendships within their ethnic group. Only a few had developed comfortable, close relationships with American students.

In summary, students who had received a psychiatric diagnosis and were rated as functioning low on the CGAS were more likely to be seen by the classroom teacher as emotionally withdrawn and daydreaming.

Case Vignette

Illustrating the kinds of information obtained from the psychiatric interview, and school and home ratings, we present the following case example:

A 16-year-old Cambodian female student became very upset in the classroom of one of the ESL teachers in October 1983. A classroom film on China evoked several symptoms of acute posttraumatic stress in this girl who later explained that certain pictures of China recalled a past experience in which she again witnessed the execution of 200 people.

Most of her psychiatric interview required an interpreter. We learned that she had been in this country about 15 months, and was currently living in an American foster home with a younger sister. For the first 6 months of her school experience, she did well. The following 6 months, however, were different. She began to miss school and complain of headaches. Very depressed and suicidal, she finally sought help and had been seen in psychotherapy by another professional at the time of our interview. She stated she was feeling better and confessed that the reason she had earlier felt suicidal was that she was "thinking too much." She was not able to sleep well and could not concentrate on her studies.

She was 9 years old and living in Phnom Penh with her family of 6 siblings when Pol Pot came to power. Her father, a military officer, was stationed in another country and had earlier urged the family to leave the country, but they had refused. He finally returned home to his family, but had to change his name and identity to survive.

Shortly the family was separated and sent to different work camps. The preadolescent girl was sent with her mother to one of the worst of these which was in essence a starvation camp. Her mother was pregnant and starving during this time. The daughter attempted to get extra food for her, but was afraid to steal food because of an automatic death penalty. Her mother died after childbirth, but the child survived and now lives with her sister in Portland. Over the 4 years of this camp's existence, only 700 of the original 2,000 people survived.

During the ordeal of the work camps, her father committed suicide; one sister and one brother died of starvation; one brother-in-law, a surgeon, was executed; both grandparents died. She had to hide the fact that she had 4 years of formal schooling. When escaping to Thailand with her sister, in order to hide her identity she changed her name. In the Thailand refugee camp she found a sister and brother.

The review of her present and past symptoms elicited sufficient disturbance to qualify her for both the DSM-III diagnoses of the PTSD and a major depressive disorder.

One of the more striking aspects of her symptoms was her declaration that she had ceased to care as much about other people as she used to. She also noted that she avoided getting involved in school activities, homework, and friendships. When we asked her how long she might live, she smiled ruefully and said, "Maybe I'll die tomorrow."

After we reviewed the interview material, she was assigned an overall score of 47 on the CGAS. A score of 47 is in the category of 41–50: "Moderate degree of interference in functioning in most social areas or severe impairment of function in one area, such as might result from, for example, suicidal preoccupation, school refusal, etc." (Shaffer et al., 1983).

In the several teacher ratings made over the last 6 months, there was one consistent pattern: she frequently daydreamed, was emotionally withdrawn, and did not participate in class discussions. Less consistent were the ratings she received on academic issues, such as completing assignments. Two ESL teachers scored her as below average on their global ratings in overall academic skills and in motivation to learn. In her overall sociability, she was noted to remain close to a small group of Cambodian students. Her GPA had dropped from a 3.0 the previous 6 months, to a 1.1 during the following 6 months.

She now lives in an American foster home with several other Cambodian youths and American foster children. She was described by the foster mother in the home interview as having many worries about her health, but not as posing any behavioral problems. Her troubles in school were recognized, but she was seen by the foster mother as being reasonably sociable. She had shared some of her Pol Pot experiences with her foster mother.

Discussion

In general, these Cambodian adolescent survivors seemed to be experiencing a greater amount of suffering than their caretakers realized. They were more anxious about their school work, had worries about friends, and complained of symptoms of depression at a higher rate than that reported by their parents. While we did not do formal psychiatric assessments on the parents, the frequency of their reported symptoms during the home interview revealed much PTSD and depressive symptoms. The suffering of the students was manifest in the classroom by the predominant symptoms of daydreaming and emotional withdrawal rather than by verbal complaints or disruptive behavior.

Irrespective of the economic and physical conditions of the homes, all of the families were successful in maintaining traditional child-rearing practices with high expectations for conformity. This was true even in families where older siblings functioned as an adult figure. Clear adult-child boundaries were maintained with a high level of filial piety. This high degree of interdependency and compliance is not simply the result of the extreme trauma these families endured. It is important to emphasize that all these children completed approximately the first 8 years of their development before Pol Pot. Cambodian children are thought to be independent at birth and then are wooed into a sense of interdependency by attentive, indulgent child rearing from multiple parenting persons. Parents become increasingly strict in their expectations for conformity and responsibility after their children reach age 7. Compliance is based less on emotional relationships between child and parents and more on respect for authority. Responsibility for honoring the family name is learned early. Adolescence in traditional Cambodian families is usually not accompanied by overt emancipation struggles. Respect for elders' authority is undiminished even as the children are apprenticed into adult status by work or marriage—both of which may come during teenage years (Tobin and Friedman, 1984). After years of living alone, the teenagers in our study who now lived with natural family members exhibited none of the rebellious, predelinquent behavior that has been described in some survivors of other disasters (Newman, 1976).

Foster children were not so fortunate. Bereft of their own families, most had been living independently for several years before living in their foster homes. They occasionally complained that family supervision was too strict. One student complained in terms that were suggestive of work camp experiences under the Pol Pot cadre. He quoted the foster mother as saying to the family. "If anyone says anything, I'll beat his head in."

The issue is more complicated than being "strict." For example, one foster boy who complained about the strict curfew rules later admitted that he did not go out at night because he was afraid. This same boy said that he did not think his family liked him, consequently he felt isolated. For him the close supervision was not embedded in shared loyalty and respect for a common family name. Even good relationships with the foster parents could not easily replace his own family identity. At the same time, this student stated clearly his need for having traditional family support and his unreadiness to move out and live independently. A typical comment was, "There is nobody to help me if I leave home." These findings should not minimize the tremendous dedication and commitment of the foster parents we met in this study. They were uniformly compassionate people.

We did find clear-cut connections between the classroom behavior of this group of Cambodian refugee students and the information they gave in a single psychiatric assessment. Despite their past suffering, and family and educational disruptions, these students performed relatively well in academic classroom assessments. That is, they performed academic tasks reliably. Yet, manifestations of their suffering showed up in certain classroom *behaviors*. We found that classroom behavioral items correlated with our psychiatric assessment while academic items did not. This was a consistent finding, whether we used presence or absence of any psychiatric diagnosis, or the CGAS as our independent variable.

Of the classroom behaviors that might suggest suffering in such a refugee group as this, emotional withdrawal, daydreaming, and nonparticipation in class would seem to be the most consistent and sensitive clues to inner psychological turmoil. In contrast to the American adolescent who might be more likely to act out problems by disruptive or oppositional behavior, the Cambodian adolescent seemed to withdraw as a way of coping. This disparity between school performance and behavior was also found by Terr (1983) in her study of 25 "Chowchilla children." Despite their extensive inner turmoil, only 4 of the 25 children of the Chowchilla kidnapping exhibited problems in academic performance.

Because the Cambodian student brings to the American educational experience a deep commitment to learning and a respect for the teacher as a revered authority figure, responsibilities and opportunities for ESL teachers are of great significance. During the course of this study we noted the skill with which these teachers played a variety of roles in addition to their traditional one of imparting knowledge: (1) They often were assigned by the students to be *counselors* and friends, listening to concerns, answering questions, and correcting misconceptions. (2) They became *case finders* for both physical health and mental health concerns in the refugee students. Seven of these 46 students had been referred for psychiatric services in the Southeast Asian Psychiatric Clinic at the Oregon Health Sciences University. (3) They were *advocates*. They helped students find part-time and full-time jobs. They interpreted their needs and vulnerabilities to other teachers. (4) They were both *students of* and *endorsers of the Cambodian culture*. For instance, they arranged all school assemblies in which Southeast Asian students could perform traditional dances. They occasionally attended community traditional ceremonies and tried to learn bits of the Cambodian language. (5) Finally, they were the main *"bearers" of American culture* to these students, in helping them to understand American customs and traditions. Because of their good relationships with these students, 46 out of 54 available students participated in this study.

We feel that such students, new to the United States, should be allowed to remain in school as long as necessary to make the major and difficult transition to our culture. The move to individual independence may be a formidable one for these students, coming from a country where family solidarity is more highly prized than personal autonomy. As representatives of a culture that has been largely ignorant of the Pol Pot atrocities (or has tried to ignore them), we present this family and psychoeducational data in the hope that all who work with such students can be increasingly sensitive to their past traumas and future needs. It is important to determine how these students adjust to the major life changes involved in leaving school and their families and weeking work or other education away from home. We intend to follow up these students in 2 years to determine the effects of the changes on psychiatric symptoms and social adjustment.

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APPENDIX H

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Children of Holocaust Survivors

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Abstract

As a result of the Holocaust, many survivors developed long-term psychosocial impairement known as the Post-Traumatic Stress Disorder (PTSD). Due to their inability to individuate from their parents, by adolescence, many offspring of Holocaust survivors began to exhibit PTSD symptoms. The purpose of this paper is to review the literature on children of Holocaust survivors and present some of my findings from interviews with them. I will describe the symptboms exhibited by Holocaust survivors and their children, explain the transmission porcess, and finally offer suggestion to clinicans working with children of survivors of any catastrophe.

"The fathers have eaten a sour grape, and the children's teeth are set on edge." Jeremiah 31:29[1]

Introduction

Social supporters clearly benefit victims of catastroph (Burge, 1983). When victims rely too heavily on too few supporters, however, these drained supporters can develop psychosocial impairment themselves (Kishur, 1983). An example of drained supporters who develop impairment is children of Holocaust survivors. In this paper I will review the literature on Holocaust survivors' children and present some of my findings from interviews with them. I will describe the symptoms exhibited by Holocaust survivors and their children, explain the transmission process, and finally offer some suggestions to clinicians working with offspring of survivors of any catastrophe.

Symptoms

Although the Holocaust occurred over forty years ago, many survivors and their children are still exhibiting psychosocial impairment. Although not all survivors exhibit impairment, it is impossible to know the incidence of those who do, since there are few statistics on Holocaust survivors in the general population. In 1956 the Concentration Camp Syndrome (Niederland, 1968) was the specific name given to the symptoms exhibited by Holocaust survivors. These symptoms include inability to concentrate, depression, inability to express anger, anxiety, psychosomatic illness and hypocondriasis, nightmares, insomnia, obsessive thoughts about the Holocaust, survivor guilt, mistrust, and estrangement from others (Danieli, 1981;1982; Eitenger, 1980; Koenig, 1964; Niederland, 1968). In 1980 the DSM III (APA, 1980) characterized most of these symptoms occurring in offspring of any catastrophe as the Post-Traumatic Stress Disorder (PTSD).

By adolescence many offspring of Holocaust survivors began exhibiting the same symptoms as their parents, and some sought psychotherapy. The symptoms they exhibited were inability to concentrate, inability to express and control anger, depression, psychosomatic illness, lack of individuality, mistrust, estrangement from others, guilt (Barocas, 1975; Danieli, 1981;1982; Epstein, 1979; Phillips, 1978; Russell, 1980; Rustin & Lipspig, 1972; Sigal, Silver, Rakoff, & Ellin, 1973; Steinitz & Szony, 1975; Timmick, 1981), nightmares and drug abuse (Scheider, 1978; Timmick, 1981). Thus, without having experienced their parents' traumatic event, these children exhibited the same symptoms as their Holocaust survivor parents. In 1980, I interivewed eleven offspring of Holocaust survivors. All of these eleven reported some of these symptoms I just mentioned.

One example is my interview with Marc W., age twenty-one. (Marc W. is a pseudonym). In grammar school, Marc began collecting books on the Holocaust. He read and re-read passages of these books to his friends, and became annoyed that they did not take the Holocaust as seriously as he did. In grammar school, he often threatened suicide, and at age eleven, he made an unsuccessful attempt by throwing himself in front of a moving school bus. By junior high school, Marc became a heavy drug abuser and drug dealer. He became the leader of a cohesive gang who sold drugs for him and stole for him by robbing houses and shoplifting. Although he overdosed on drugs several times in high school, he was unclear whether any of these overdoses was a suicide attempt. Marc managed to graduate high school and was admitted to college. During his first year in college, his father died. Marc blamed himself for his father's death, and reports making a conscious effort to change his lifestyle. He quit drugs, disbanded his gang, and began to take his studies seriously. Presently he is in his last year of law school, and plans on taking aMasters in international law. Although Marc seems to overcome his problems in adulthood, I am not implying that in all cases impairment ends by adulthood.

Process of PTSD Transmission

The literature clearly documents that the effects of the Holocaust are transgenerational, and this case study is an illustration of the process. In order to prevent second generation effects from occurring in other catastrophes, we need to know not only *that* the transmission occurs, but *how* it occurs. There is growing consensus in the Holocaust literature that the transmission from parents to children occurs by the inability to individuate from one's parents and establish one's own identity (Barocas, 1975; Danieli, 1981; 1982; Phillips, 1978; Russell, 1980; Steinitz & Szony, 1975; Wanderman, 1975). In transmitting traumatization from parents to children, the normative process of identification is impaired.

Instead of allowing the children to establish their own identities, the parents try to hammer their identities into their children. The parents view their children as symbols to compensate for all they have lost and suffered, and the children readily assume this responsibility (Barocas, 1975; Danieli, 1981;1982; Epstein, 1979; Russell, 1980; Steinitz & Szony, 1975; Wanderman, 1975). Helen Epstein (1979) an author of a book on children of Holocaust survivors quotes this perception of responsibility from a survivor child who says:

> I knew my parents had crossed a chasm, and that each of them had crossed it alone. I was their first companion, a new life, and I knew this life had to be pure life. This life was as different from death as good was from evil, and the present was from the past(p. 30).

Rather than blaming Holocaust survivors for expecting their children to compensate for all they have lost, we need to keep in mind the impact of their losses. Every person, possession, value, and belief in their lives was destroyed in the Holocaust, and they redefined their world as evil and dangerous and populated by hostile others (Bergmann & Jucovy, 1982; Danieli, 1981;1982; Eitenger, 1980; Niederland, 1968).

After the war, Holocaust survivors hastily married, but almost always other Holocaust survivors. Because they preceived all other nonHolocaust survivors as hostile, they chose mostly other survivors as their friends (Danieli, 1982; Epstein, 1979). Their children became their only substantial link to the outside world. Thus suvivors relied too heavily on too few supporters (ie. their children). Often the parents used their children as a captive audience to recount graphic details of the Holocaust experience. For many children of survivors, the responsibility of being their parents chief social supporter was too great to endure.

Thus, in expecting their children to provide their lives with meaning, survivors took from their children, but they also gave. They desperately wanted to insure that their children wiuld be safe in a world in which Holocausts can occur. To insure safety, they taught their children that the world was hostile, and that they must always be on gaurd (Barocas, 1975; Danieli, 1981;1982; Epstein, 1979; Sigal et al., 1973; Steinitz & Szony, 1975; Wanderman, 1975; Timmick, 1981). Although the children's experience did not fit their parents' worldview, they were taught to be mistrustful enough of outsiders and guilt-ridden towards their parents that they accepted their parents' worldview. Apparently they identified with their parents so closely, that like their parents, they developed PTSD symptoms.

Although the components of Erikson's theory of identity formation are used consistently to explain the symptoms of children of survivors, none of the Holocaust researchers explicitly uses Erikson's theory to explain the survivor's child's difficulties. I will therefore briefly explain their identity formation using Erikson's framework.

First of all, children of Holocaust survivors' attempt to individuate was problematic, since it was different from that of their peers. Normally, according to Erikson's theory, identity formation involves a sorting out of all former identifications in which the influences of others are resynthesized into the adolescent's unique identity (Erikson, 1968). In the case of children of survivors, their parents demanded total conformity to their own identities, so that no selecting was possible (Barocas, 1975; Danieli, 1981;1982; Russell, 1980).

Moreover, these adolescents were not prepared to individuate, since their previous developmental stages have not been mastered. According to Erikson, the childhood tasks are trust, autonomy, initiative, and industry (Erikson, 1968). If these tasks are not mastered, impairment rather than identity formation will result.

From the onset, children of survivors never completed the initial trust stage. They were taught to mistrust (Danieli, 1981;1982; Epstein, 1979; Sigal et al., 1973; Steinitz & Szony, 1975; Wanderman, 1975; Timmick, 1981).

Consequently none of the other stages were allowed to develop. In place of autonomy, children were taught shame and guilt (Barocas, 1975; Epstein, 1979; Phillips, 1978; Rustin & Lipsig, 1972; Sigal & Rakoff, 1971). Industry was encouraged but inconsistently. On one hand, high achievement in school was encouraged, yet the adolescent felt guilty for surpassing the accomplishmants of his/her parents (Danieli, 1981; 1982; Epstain, 1979; Phillips, 1978).

Also, according to Erikson (1968), these children could not possibly have learned trust, autonomy, initiative, and industry, if their parents did not possess these qualities themselves. According to Koenig (1964) as a result of the Holocaust, survivors suffered ego regression and thus had not mastered any of these tasks themselves.

Thus, unlike their peers, children of Holocaust surviors were unable to individuate from their parents and in their struggle to individuate, they developed PTSD symptoms. According to Bergmann and Jucovy (1982) the task of adolscents of survivors was different from that of their peers in this way:

> The task of survivors' children who are becoming adults is to understand their parents' past experience without degrading or idealizing them. In one sense, this task is not different from that of other young adults growing into adulthood. Yet, it is different in that it concurs a reality that defies trust in human nature and creates obstacles to the young person's need to understand history as a basis for the present and the future (p.61).

Suggestions for Clinicians

By late adolescence, many children of Holocaust survivors sought psychotherapy for PTSD symptoms. Clinicans who have worked with children of survivors have written of their difficulty in working with them (Russell, 1980; Rustin & Lipsig, 1972). Therapists tend to blame the client for not understanding their parents' traumatic expereince instead of viewing the client as a victim of the Holocaust as well.

The type of therapy which seems to be successful for survivors and their children is group therapy with fellow survivors (Danieli, 1982; Russell, 1980). Danieli has tried support groups involving both generations. A group of fellow survivors and children can help each other to recognize their losses and then attempt to restore a sense of continuity, belonging, and rootedness. One of the strategies Danieli uses to reach these goals to is have group members construct a three generational family tree.

Conclusions

Thus we know that not only survivors, but their children as well are traumatized by the Holocaust. From this we can hypothesize that children of survivors of other catastrophes such as Vietnam veterans, burn victims, rape victims, etc. may identify with their parents to the extent that they develop the same symptoms. Perhaps we can use this information to assess parent-child interaction of such groups to determine whether the transmission of PTSD is occurring and develop intervention programs to counteract this.

Finally, I want to emphasize that for most people, the Holocaust is simply history. We need to be reminded, therefore, that for some survivors and their children, catastrophes such as the Holocaust are not history; They are a part of their everyday lives.

APPENDIX 1

The International Catholic Child Bureau (ICCB)
Bureau International Catholique de l'Enfance (BICE)

Reasons for Living and Hoping:

CHUNG EM VUI RUOC DEN
QUOC VIET

roceedings from the Multi-Disciplinary, Inter-Religious Conference
n the Spiritual and Psycho-Social Needs of Southeast Asian
efugee Children and Youth Resettled in the United States

October 16-18, 1988
Washington, D.C.

☐ An Intergenerational Program Designed for Holocaust Survivors and Their Children

Dr. Yael Danieli
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Group Projects for Holocaust Survivors and Their Children
New York, New York

I have travelled through five continents. A multi-cultural perspective has been mine from birth. I've been touched very deeply by my work with survivors of the Holocaust, contributions to treatment of the Aborigines in Australia, and earthquake victims and survivors of other dramatically terrible events. Hopefully, I help, and, hopefully, I do a little bit to make the world a better place. This ultimately propels me. I want to share with you the actual feeling that propels me in my work—whether it's my own project because I built it, or other projects because I hear of them or I'm in some way connected to them. These are the words of Eli Wiesel:

> *After the reckoning, one feels discouragement and shame. The balance sheet is disheartening. Society has changed so little that only one conclusion is possible. Mainly, the failure of the black years has begotten yet another failure. Nothing has been learned. Auschwitz is not even served as a warning.*

Now that's from the perpetrator's point of view. I'm quite determined in light of my life that from the service-providing point of view and from the lessons we can learn as human beings from what evil does, we can make the world a better place.

> *The sun made a desperate effort to shine on the last day of May in 1944. The sun is warming in May. It heals. But even the heavens were helpless on that day. A force so evil ruled heaven and earth that it altered the natural order of the universe. And the heart of my mother was floating in the smoke-filled sky of Auschwitz. I have tried to rub the smoke out of my vision for forty years now, but my eyes are still burning, Mother.*

Later, in America, Isabella, who is one of the participants in the project that we built, tells of her mother, who lived for just a while:

> *In a way she didn't really die, she simply became smoke. How does one bury smoke? How does one place headstones in the sky? How does one bring flowers to the clouds? Mother, I'm trying to say goodbye to you. I am trying to say goodbye.*

Her poignant questions articulate but a few of the numerous obstacles which have confronted survivors and children of survivors of the Nazi Holocaust. After liberation, as during the war, survivors were victims of a perversive societal reaction comprised of obtuseness, indifference, avoidance, depression, and denial of their Holocaust experiences. Like other victims, survivors' war accounts were too horrifying for most people to listen to or believe. Similar to other victims who are blamed for their victimization, survivors were faced with a pervasively held myth that they had actively or passively participated in their own destiny by "going like sheep to the slaughter." This myth implied not only that they could have fought and that they should have been prepared for the Holocaust as if anyone was or could have been. But it also assumed that the Holocaust victims had somewhere to go if they chose to escape and that the rest of the world wanted them, which was clearly not the case.

Additionally, by standards, guilt lead many to regard the survivors as pointing an accusing finger at them and to project on to the survivors the suspicion that they had performed an immoral act in order to survive. Like other victims, they were also told to let bygones be bygones and to get on with their lives. These reactions insured the survivors' silence about their Holocaust experience. They were forced to conclude that nobody cared to listen and that nobody could really understand them unless they had gone through the same experiences. The resulting conspiracy of silence between Holocaust survivors and society proved detrimental to the survivors' familial and societal cultural integration by intensifying the already profound sense of isolation, loneliness, and mistrust of society. This further impeded the possibility of the interacting, integration, and healing and made their task of mourning their massive losses impossible. Psychotherapists have also typically participated in the conspiracy of silence when survivors mentioned or recounted the Holocaust experiences. In one study, I've identified and systematically examined psychotherapists' counter-transference reactions. My research discovered 49 such reactions.

In analyzing the sources of these reactions, what I discovered is that it is the Holocaust rather than the actual encounter with the survivors or their children. It is the imagination that the therapist has about whatever the Holocaust was that renders the therapist blind and deaf, wanting not to hear or not to see. And I strongly believe that therapists' difficulties in treating

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other victims—survivors and refugees included under that phrase—may similarly have their roots in the nature of their victimizations. As I said before, such reactions have insured the survivors' silence about their Holocaust experiences. The only option left to survivors other than total solitude or sharing of the Holocaust experience with each other was to withdraw completely into the newly established families. Children of such families, although remembering their parents' and lost families' war histories, as they say, only in bits and pieces, attended to the psychological presence of the Holocaust at home at all times, both verbally and non verbally. In contrast, other survivors welcomed the conspiracy of silence because of their fear that their memories would corrode their own lives and prevent their children from becoming healthy "normal Americans". We touched yesterday in the groups in other discussions about the need to belong and what that does. And what does "normal American" mean, and what does it call upon us to be or become or not become?

But the children grew up in painful bewilderment. They neither understood the inexplicable terror within their families nor their own sense of guilt. The children of survivors seem to have consciously and unconsciously absorbed their parents' Holocaust experiences into their lives. Holocaust survivors' parents, in the attempt to give their best, taught them how to survive, and in the process, transmitted to them the life condition under which they had survived the war. Thus, one finds children of survivors who psychologically and sometimes literally live in hiding. Others are always ready to escape or continuously run from relationships with people, from commitment to a career, or from one place of residence or country or another. Some keep split or double fake identities. Yet others adopt a resigned pacificatory as their motive be in a world that they experienced at the concentration camp.

We see tireless manipulators and those in whom whatever they do are resistent fighters. These modes of being are manifested in their language, behavior, fantasy life and dreams. Many children of survivors, like their parents, manifest these Holocaust-derived behaviors particularly on anniversaries. Moreover, some have internalized as part of their identities the images of those who perished and have simultaneously lived in different places, like in Europe and in America and in different time zones, such as in 1942 and 1988. The therapist, therefore, must be able to encompass that. When you talk about different souls, it's so similar that we can only be full of wonderment about the wisdom of different religions that may coincide with bringing goodness to the world.

Most families of survivors are extremely small. The Holocaust deprived the normal cycle of the generations and ages and of natural death. Survivors on a whole die five years prematurely. The Holocaust took six years of their lives with all their losses, and also reduced the length of their lives when they survived by another five years. They die of all causes, including physical illness and suicide. They're more physically ill than the rest of the population, as well. Each family tree is steeped in death and losses, yet its offspring are expected to re-root that tree and re-establish the extended family, starting a new and healthy generational cycle. They are expected to do so, despite conscious and unconscious resentment against the Nazis and against humankind. They have not had grandparents and relatives; they have been cheated of normal parents and a normal childhood. They have felt different and isolated; they fear another Holocaust. For them, love will mean potential loss. They deeply comprehend that when their own parents say, "You are the only one I have," this is often literally true. These feelings are particularly poignant when survivors approach old age. This is very important. Many Americans will call this a neurotic manipulation by the parents. However, it is quite different when this is the person's reality.

A Program Model

The Group Project for Holocaust Survivors and Their Children was established to counteract the profound sense of isolation and alienation among Holocaust survivors and their children. Formally established in 1975 by volunteer therapists in the

New York City area, the project recognized the vital importance of self-help towards reaching its goals and has capitalized on group and community therapeutic modalities from its inception. In fact, most professionals who have remained with the project are themselves survivors or children of survivors, underscoring the self-help orientation.

By participating in groups, survivors and the children of survivors were able at last to talk about their memories and experiences. They were also able to explore with each other and comprehend the Holocaust's long-term consequences on their lives and share their feelings and concerns. No a priori design existed for the project. Formal methods of treatment developed gradually through trial and error. Flexibility of approach and feedback from survivors and their offspring were most helpful. While acknowledging the long-term effects of the Holocaust and post-Holocaust experience on its survivors and their children, at no point did the project organize and view these individuals as sick or pathological. Survivors' resistance to institutions, their fear of being stigmatized, labeled crazy (stemming from the Nazi practices of gassing the sick and mentally ill), or considered psychologically damaged by the victimization specifically precluded making the project part of the mental health facility. Of course, they are not crazy. All of the suffering makes perfect sense according to their history. They also have many sources of fears that could be labeled. We chose, therefore, not to make our project part of an existing mental health facility.

The project today provides individual family group and intergenerational community assistance in a variety of non-institutional settings. Its goals, which are preventive as well as reparative, are predicated on two major assumptions: one, the integration of Holocaust experiences into the totality of their lives and awareness of the meaning of post-Holocaust dictatorial styles will be liberating and potentially self-actualizing; and two, that awareness of transmitted inter-generational processes will inhibit transmission of pathological behavior to succeeding generations.

This is very important because what we have learned is that if you do not help people right after the victimization and if you do not provide the right kind of help, the next generation and possibly the next generation will also be diseased with the original trauma.

This project's central guiding principle is integration, which in the case of victimization means integrating the extraordinary into one's life—that is, confronting and incorporating aspects of human existence that are not normally encountered in ordinary everyday life. In extreme cases, such as massive catastrophes of the Nazi Holocaust and other holocausts such as yours, victimization not only ruptured continually, but also destroyed all of the individual existing supports. A conspiracy of silence exasperated the situation by further depriving the victim survivors of potential support. Especially, the rupture of victimization rarely has the meaning of "going back to normal." This is true both in terms of re-adopting to "normal society" or returning to prior ways of being and functioning. In fact, the hope of resurrecting their previous lives is unrealizable. Moreover, clinging to such hope may represent a denial of their victimization experiences, which includes feelings of grief, shame, hurt, and guilt.

In contrast, integration and recovery in our formulation involves the victim survivor's ability to develop a realistic perspective of what happened and to identify by whom and to whom the victimization occurred, so they then accept the reality that it happened the way it did. For example, what was and was not under his or her control and what could not be and why are explored. Accepting the impersonality of the events also removes the need to attribute personal causality and consequently guilt in false responsibility. An educated and contained image of the events of victimization potentially frees one from constructing a view of oneself and of humanity solely on the basis of these events. We have learned that our aims are not just to "make people feel better." We intend to help people get better. On a whole, not just to feel better for the short run.

Importance of Mutual Support for Healing

I would like to elaborate further on the reparative value of mutual support in counteracting the survivors' and the children of survivors' sense of isolation and alienation. Survivors rarely say "I". They say "we". It was a massive group murder. That is important to recognize in what you propose as a healing modality. These modalities acknowledge that perhaps only collectively can they find a meaningful response to their horrific history of victimization. Collectively they can best work through their experiences of survivors' guilt and its multiple meanings. They have a necessary, although impossible, task of mourning their massive losses. They blocked responses to the victimizers and to the world that let the Nazis systematically murder 6 million of their people – 1-1/2 million of whom were children.

They experience a sense of shame about witnessing the boundlessness of evil and the fall of civilization and review the meaning of being a Jew and their belief in God after the Holocaust. Psychotherapists customarily would not talk about religion with their patients. We try to return to that since it is such an important part of identity.

Groups and communities established by the projects served to help rebuild the sense of extended family community which were lost during the Holocaust and also help the therapy. The group's therapists may feel overwhelmed by these stories but have eight other survivors or children of survivors sitting there who may be able to listen. They help the therapist feel less burdened, and they do not have to deal with all of this horror alone. That is very important because therapists alone can become enabled to provide what we call a holding environment. It is so needed for the sense of belonging. The group may compensate for that. While any particular intense interaction invoked by memories may prove too overwhelming to some, others do provide the holding reactions. Thus, the group functions as an ideal absorbed entity for our expression of emotions, especially negative ones that are otherwise experienced as un-containable. The group also offers a multiplicity of options for expressing feelings, naming, verbalizing, and modulating them. This is very important because many survivors say they do not have words to describe or express both the events and what they feel. The group as a whole puts the words together. We find words, even songs or whatever, to do express something. It also is a safe place for exploring fantasies, imagining and inviting relatives. I invite also the souls of the family. Sometimes we invite the Nazis, as well, by the way, if somebody needs to tell them how they feel. In fantasies you can do so much work. They take on roles of murdered relatives or victims examining the significance in the identity of the survivor or offspring. Another aspect is to identify and observe other victim-derived behaviors and help group members recognize their own using the peer group for confrontation.

The group confronts the member, and then next time the member may recognize that reaction in somebody else's story, and it is very helpful. Peer groups are much more powerful than therapists alone. The groups can safely test out new behaviors and receive feedback about the impact on others. That's a safe laboratory, rather than out there in the world where you can be knocked and feel rejected again.

We provide individual therapy and family therapy. Family is very important in the context of relatedness. We provide group therapy and group therapy as awareness groups. We have multiple family groups, where one family learns from the other. We have inter-generational community meetings. Every two months on a Sunday from 1 p.m. to 4 p.m., we hold an inter-generational community meeting, where everyone is invited. We invite the survivors and the children of survivors who are participating in the project. We include neighbors. The project compensates for the loss of family and extended family and community. We build a community for people who no longer have one at all and who gave up hope of ever having one. We begin it by sharing good news and bad news of members. We begin by finding out if anybody is sick and needs volunteer help to visit them in the hospital because some people, as I said, are totally alone in the world. We do all kinds of combinations in the community, as I shared yesterday. We have grandparents adopted by children without parents and without grandparents, and they help each other.

It is not only during the meeting that we do a lot of sharing. For example, last meeting somebody wrote a song, and we began by singing the song. We promote creativity in the community from within the community. We have at least eight books written by members. Isabella, the woman whose poem I read at the beginning, is a member that was inspired by another. He expressed that if he started crying he would never stop. Or if he started screaming he would shake the whole universe. So people try to put it in writing. They try to express it in sculpture and in paintings. We have had films develop through projects. We have had marriages happen among family members. I am a grandmother for quite a few little babies and a Godmother for a few, as well, and I am not the only one. So we have a community. We have a community that inspires and that is inspired by itself.

I want to emphasize the importance of reliance on community resources and on volunteer work – not just professional work but volunteer spirits within the community and outside of the community, between the community and the rest of the surrounding communities. It is very healing to see volunteers work as healers, not only to the receiver, but very often to themselves. You can create a very wonderful opportunity for people to be good and create something good.

APPENDIX J

RATNA TRAUMA I OPORAVAK

Ova brošura je namijenjena svima vama: muškarcima, ženama, djeci; mladima i starima; iz gradova i sela; svima vama koji ste bili ili ste još uvijek izloženi ratnim stradanjima i životno opasnim situacijama. Vama koji ste bili izloženi nasilju ili ste bili svjedoci nasilja; vama koji ste izgubili svoje domove i svu imovinu; vama koji ste izgubili drage i bližnje u ovom ratu; svima vama koji ste raseljeni; vama čiji su prijatelji i članovi obitelji bili izloženi stravičnim iskustvima; ali i vama koji ste u različitim situacijama i okolnostima samo slušali o ratnim strahotama. Svi vi vrlo vjerojatno proživljavate osjećaje za koje niste bili pripremljeni i s kojima vjerojatno ne znate kako izaći na kraj. Za mnoge od vas traumatska iskustva još uvijek traju i trajat će jos neko vrijeme. Upravo zato, vrlo je važno da odmah počnete voditi brigu o svim ovim temama, i ne čekate da se sve dovrši i sredi samo po sebi. Svrha ove brošure je da vam pokuša pomoći u razumijevanju vlastitih rakcija i reakcija vama bliskih ljudi te da vam predloži načine za uspješnije prebrodjivanje ove teške situacije.

ŠTO JE NORMALNA REAKCIJA?

U traumatskim situacijama ljudi ragiraju vrlo različito. Čak i u sklopu iste situacije ljudi često ragiraju na različite načine. Neki ljudi imaju momentalne reakcije, dok drugi reagiraju kasnije (ponekad čak nekoliko godina nakon traumatskog iskustva). Ako vas brinu vaše reakcije ili reakcije vaših bližnjih, zapamtite da postoji cijeli niz reakcija na veoma teške situacije (kao sto su ratne strahote) koje smatramo normalnim.

Važno je napomenuti da se reakcije takodjer mogu javiti kod ljudi koji nisu bili direktno izloženi nasilju vec su bili svjedoci nasilja, kao i kod ljudi koji su zabrinuti za vlastitu sigurnost ili sigurnost bližnjih. Razumijevanje vlastitih i tudjih reakcija može biti od pomoći u procesu oporavka.

KAKO LJUDI REAGIRAJU?

Prve reakcije u traumatskim situacijama obično uključuju šok, nevjerovanje da se to stvarno dogadja, potpuni gubitak svih osjećaja, povlačenje i negiranje. Kasnije osoba može osjećati ljutnju, bijes, strah, tugu, zbunjenost, užas, osjećaj krivnje, razdraženost kao i cijeli niz drugih osjećaja. Iako se reakcije razlikuju od osobe do osobe, postoji odredjen raspon uobičajenih reakcija i osjećaja koji se tipično javlja kod ljudi koji su bili izloženi dugotrajnom i ponavljanom nasilju.

Traumatsko iskustvo može utjecati na gotovo sva područja života: na razmišljanje, osjećaje, ponašanje, tjelesno zdravlje, duhovnost i medjuljudske odnose. Navodimo djelomičnu listu reakcija koje se obično javljaju kod ljudi koji su bili izloženi nasilju i sličnim traumatskim iskustvima. Bilo koja kombinacija ovih ili sličnih reakcija je u granicama normalnog.

NEKE UOBIČAJENE REAKCIJE

Osjećaji

Osjećaj nemoći beznadnosti i bespomoćnosti
Tuga
Potpuni gubitak osjećaja
Užas, strah, briga za vlastitu sigurnost
Osjećaj krivice
Osjećaj ranjivosti i ovisnosti
Bijes, ljutnja
Nagle i ekstremne promjene raspoloženja
Noćne more
Osjećaj bezvrijednosti
Osjećaj izoliranosti
Osjećaj gubitka kontrole nad vlastitim životom
Osjećaj prljavosti
Strah od toga što drugi ljudi misle
Strah od trajne izloženosti nasilju

Mišljenje

Teškoće u prisjećanju i pamćenju
Teškoće pri donošenju odluka
Zbunjenost
Teškoće u održavanju pozornosti
Previše misli odjednom
Razmišljanje o samoubojstvu
Iznenadne slike traumatskog doživljaja
Stalno razmišljanje o traumatskom dogadjaju
Iskrivljen doživljaj vremena

Duhovne

Gubitak vjere
Duhovne sumnje
Povlačenje iz crkvene zajednice
Očaj
Prestanak prakticiranja vjere
Sumnje u prijašnja vjerovanja
Osjećaj da je svijet promijenjen "naglavačke"

Tjelesne

Umor
Poteskoće sa snom/spavanjem
Problemi s apetitom i hranom
Povraćanje, proljev
Želučane smetnje
Znojenje, ubrzani puls
Bolovi u prsima
Vrtoglavice, glavobolje
Bolovi u ledjima ili vratu
Česte prehlade i gripe

Ponašanje

Zloupotreba alkohola, droga i tableta
Povlačenje od ljudi
Pretjerana ovisnost o drugim ljudima
Razdražljivost, nestrpljivost
Snažne reakcije na male promjene u okolini (zvukove, ljude)
Nemogućnost obavljanja zadataka koje ste ranije obavljali bez poteskoća
Narušenje dnevne rutine

Medjuljudski odnosi

Teskoće u vjerovanju ljudima
Promjene u seksualnim aktivnostima
Pogrešna ili iskrivljena uopćavanja o drugim ljudima
Sumnjanje u emocionalne veze
Osjećaj kritičnosti prema drugim ljudima
Udaljavanje od obitelji, prijatelja i kolega koji vas "ne razumiju"
Osjećaj usamljenosti

POSEBNI SLUČAJEVI : SILOVANJE I TORTURA

Silovanje i tortura zahtijevaju posebnu pozornost zbog karakterističnih problema koji se javljaju kao poslijedice. Iskustvo silovanja ali i samo prisustvo silovanju i/ili torturi mogu onemogućiti osobu da u potpunosti sudjeluje u životu obitelji, zajednice i društva. Osim osjećaja ugroženosti vlastitog života, iskustvo torture ili silovanja može ugroziti ili uništiti osjećaj ljudskog dostojanstva, vlastite vrijednosti i povjerenja u druge ljude. Povjerenje u druge može biti naročito narušeno ako je napadač poznata osoba.

Nasuprot uobičajenom vjerovanju, silovanje nema pune veze sa seksom. Silovanje je primjer zlouptrebe sile i moći nad drugom osobom pri čemu je glavni cilj silovatelja da ponizi, osramoti, kontrolira, zastraši i degradira žrtvu. To je u pravilu jedan od najrjedje prijavljivanih zločina širom svijeta, i u ratnim i u mirnodopskim uvjetima. Žrtve silovanja često se odlučuju ne prijaviti zločin uslijed osjećaja srama i straha. U ratnim uvjetima, prijava silovanja često djeluje još besmislenije s obzirom da vojnici imaju "dozvolu za silovanje" a i pitanje je kome uopće prijaviti zločin? Bez obzira da li odlučite prijaviti silovanje ili ne, vrlo je važno da nakon tako teškog traumatskog iskustva što prije poduzmete korake za vlastiti oporavak.

OSJEĆAJ KRIVICE : ČESTA REAKCIJA

Jedna od najčešćih reakcija nakon proživljene traume, a koju ljudi često ne razumiju, je osjećaj krivnje: Osjećaj krivnje zbog toga što vam se dogodilo, zbog toga što niste zaštitititili sebe i svoje bližnje na primjeren način, zbog toga što niste prepoznali i reagirali na znakove približavanja katastrofe, osjećaj krivnje zato što ste preživjeli, osjećaj odgovornosti za to što vam se dogodilo. **Vrlo je važno da upamtite da vi niste odgovorni za to što vam se dogodilo.**

Medjutim, oporavak od pretrpljene traume će biti ubrzan i olakšan vašim aktivnim pristupom, spremnošću i odlučnošću. Najbolje je početi s aktivnom brigom za sebe, birajući ono što vam najviše odgovara. Nema formula i recepata. Različiti pristupi pomažu različitim ljudima.

ŠTO MOŽETE UČINITI ZA SEBE?

Počnite s malim promjenama koje će vam pomoći na osobnom planu. Na primjer, vrlo je važan svaki pokušaj uspostavljanja kontrole nad vlastitim životom. Donošenje vlastitih odluka kad god je to moguće, bitno je za jačanje i ponovno uspostavljanje osjećaja vlastitog dostojanstva, samopoštovanja, ponosa i integriteta. Čak i donošenje malih odluka kao što su: kada ćete otići u šetnju i s kim ćete popiti kavu, mogu pomoći u procesu oporavka. Navodimo listu različitih oblika ponašanja koja su pomogla drugim ljudima u sličnim situacijama. Možda pomognu i vama.

* *Vodite brigu o tjelesnom zdravlju*

- Obavite liječnički pregled ako je to ikako moguće. Ako zdravstvena njega nije osigurana zatražite ju.
- Upamtite da trauma i dugotrajan stres mogu djelovati na vaše zdravlje bez obzira da li imate vidljive povrede. Brinite o svom zdravlju.

* *Pokušajte uspostaviti dnevnu rutinu*

- Jedite redovito, koliko je to moguće; smanjite i kontrolirajte konzumaciju alkohola.
- Pokušajte se odmarati redovito.
- Bavite se tjelesnim aktivnostima. Vježbajte, igrajte se s djecom, idite u šetnju - fizičke aktivnosti smanjuju utjecaj stresa.
- Uspostavite neku vrstu dnevne rutine, čak i ako se razlikuje od vaše uobičajene.

* *Vodite brigu o svojim osjećajima*

- Za oporavak je potrebno vrijeme, i to se razlikuje od osobe do osobe. Vi ste jedinstveni kao i vaše traumatske reakcije. Upravo zbog toga, usporedba vlastitih traumatskih reakcija s reakcijama drugih ljudi je potpuno beskorisna. Pustite vremenu da zaliječi vaše rane. Budite strpljivi sami sa sobom.
- Prihvatite svoje osjećaje takve kakvi jesu. Ako osjećate bijes, na primjer, ne mora značiti da ćete nekoga stvarno povrijediti. Ako se osjećate "van sebe" ne znači da stvarno nemate kontrolu nad situacijom. Ako se osjećate bespomoćni, ne znači de ste stvarno bespomoćni. Možda ste obeshrabreni ili pokolebani ali niste bespomoćni.
- Pokušajte se sjetiti što vam je ranije pomoglo u stresnim i kriznim situacijama. Upotrijebite to i sada.
- Kontakti s obitelji, prijateljima i ljudima s kojima se osjećate bliski i sigurni mogu vam pomoći, kao što su pomogli mnogim ljudima koji su preživjeli teška traumatska iskustva. Povremeno ćete možda osjećati potrebu da budete sami ili da ste stalno okruženi ljudima i - to je u redu. Slijedite svoje instinkte.
- Traumatska iskustva mogu djelovati na vaše seksualne potrebe. Razgovarajte sa svojim partnerom o tome koja razina intimnosti je prihvatljiva za oboje.
- Razgovori o traumatskim iskustvima i vašim reakcijama na njih često su korisni. Razmijena iskustava s drugim ljudima koji su proživjeli slična iskustva može vam pomoći. Često, medjutim, nije nužno da razgovarate o svim detaljima vašeg traumatskog iskustva.
- Pažljivo birajte s kim razgovarate o svojim teškim iskustvima. Neki ljudi znaju slušati i sam razgovor može biti vrlo koristan, dok se nakon razgovora s drugima možete osjećati još gore i usamljenije. Neki ljudi će moći mirno saslušati sve, dok će drugi moći podnijeti samo neke dijelove vaseg traumatskog iskustva. Slijedite svoje instinkte.
- Stručnjaci iz područja mentalnog zdravlja mogu pružiti potrebnu pomoć nekim ljudima. Čak i samo jedan odlazak na razgovor s takvim stručnjakom može vam pružiti okvir za bolje razumijevanje vaše situacije.
- Neke situacije kao što su godišnjice traumatskog dogadjaja, značajni datumi u vašem životu, ili čak neki ljudi mogu izazvati bolne uspomene. Televizijska emisija, članak u novinama ili bilo što drugo što vas podsjeća na traumatsko iskustvo može izazvati slične reakcije. Te situacije će se prirodno pojavljivati u vašem životu i nemoguće ih je izbjeći. Bilo bi korisno očekivati ih i pripremati se za njih.
- I na kraju, najvažnije što možete učiniti za sebe nakon teškog traumatskog iskustva jest uložiti svjestan napor u svrhu brige o sebi na najbolji mogući način i to na svim područjima života.

Nakon teškog traumatskog iskustva možda ćete na neki način postati pretjerano oprezni u životu. Unatoč tome, mnogi ljudi koji su proživjeli slična iskustva uspijevaju nakon odredjenog vremena ostvariti za sebe smislene živote. Za oporavak je potrebno vrijeme ali je moguć, uz prikladnu pomoć.

* * * * *

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PANEL #1

WAR TRAUMA AND RECOVERY

This brochure is for all of you, men, women, and children, old and young, from town and village, who have been exposed to ongoing traumatic war experiences and life-threatening situations: For all of you have been exposed to, or witnessed violence; for those of you who have lost your homes and all your belongings; for you who have lost loved ones in this war; for displaced people, but also for those of you whose family and friends have had terrible experiences or you who have only listened to them. You may be experiencing feelings that you have not been prepared for and don't know how to deal with. For many of you traumatic experiences are continuing and will continue for some time. Because of this, it is very important that you begin to take care of these issues immeidately and don't wait for everything to get resolved on its own. The purpose of this brochure is to help you understand your reactions and the reactions of your loved ones, and to suggest ways for successfully overcoming this difficult situation.

PANEL #2

WHAT IS A NORMAL REACTION?

People respond to traumatic experiences in a variety of different ways. They may respond differently even to the same traumatic event. ome people will have immediate reactions; others, delayed responses (perhaps even years after the experience). If you are concerned about your reactions or reactions of your loved ones, remember that there is whole range of responses to very difficult situations (such as the orros of war) that is considered to be normal.

It is important to stress that reactions may appear even among the eyewitnesses of violence, and those who worry about their safety or the safety of others. Understanding reactions can be helpful in the process of recovery from traumatic experiences.

HOW DO PEOPLE RESPOND?

Initial reaction to a traumatic event can include shock, disbelief, numbness, withdrawal and denial. Later, a person may experience anger, rage, fear, grief, confusion, guilt., terror, rustration and a variety of other feelings. Even though these reactions are individual., there is a wide range of common feelings and reactions that occur among victims of violence, especially repetitive r ongoing violence.

Experiencing trauma can affect almost every aspect of your life: cognitive, emotional, behavioral, physical, spiritual and relational. ere is a partial list of common reactions to violence and other trauamtic events. Any combination of these or similar reactions is still within normal range.

PANELS #3 & 4

SOME COMMON REACTIONS

Cognitive

difficulty remembering things
hard time making decisions
confusion
distortion of time
difficulty concentrating
too many thoughts at once
thinking about suicide
flashbacks
replaying the event

Physical

fatigue
change in sleep habits
eating/appetite problems
stomach problems
vomiting/diarrhea
sweating, rapid pulse
chest pains
dizziness, headaches
back or neck pain
catch colds or flus

Spiritual

loss of faith
spiritual doubts
withdrawal from church community
lapses in spiritual practice
questioning old beliefs
sense of the world being
  changed, out of kilter
despair

Relational

difficulty trusting
changes in sexual activity
false or distorted
  generalizations about others
doubts about relationship
feeling critical of others
alienation from family, friends
  and co-workers who "don't
  understand"
sense of aloneness

Behavioral

abusing alcohol, drugs and medication
withdrawing from people
irritability, impatience
reacting strongly to small
  changes in environment (sounds,
  visitors, etc.)
clinging to people
disruption of daily activities
inability to perform skills
  that you could do before

Emotional

feeling helpless, hopeless or
  powerless
grief
numbness
dread/fear/safety concerns
guilt
feeling vulnerable and
  dependent
anger, rage
emotional rollercoaster
nightmares
feeling worthless
feeling of isolation
feeling lack of control over
  own life
feeling of uncleanliness
fear of what other people think
fear of ongoing victimization

PANEL # 5

THE SPECIAL CASES OF RAPE AND TORTURE

Rape and torture require special attention because of specific issues related to them. Witnessing or experiencing rape and/or torture can impair a person's ability to participate fully in family life, community and society. In addition to threatening one's physical health, torture and rape can destroy one's feeling of human dignity, self-worth and trust in others. Trust in others may be particularly shaken if you have been assaulted by someone you know.

Contrary to belief, rape has little to do with sex. It is an abuse of power and control in which the rapist seeks to humiliate, shame, embarrass, degrade and terrify the victim. Rape is among the most undereported crimes worldwide, both during peacetime and war. Victims of rape often chooose not to report the crime out of shame and fear. In wartime, it often seems even less menaingful to report the rape since there is no one to report to, and soldiers may have license to rape. Regardless of whether you decide to report being raped or not, it is important that, after such a difficult traumatic experience, you take steps towards your own recovery.

GUILT: A COMMON REACTION

One of the most common reactions after experiencing trauma, one that people often don't understand, is the feeling of guilt: Guilt about what happened to you, about not protecting yourself or your loved ones adequately, about not recognizing and responding to the signs of approaching catastrophe, guilt because of surviving, feeling responsible for what has happened to you. It is very important to remember that you are not repsonsible for what has happened to you.

ANEL #6 & 7

However, recovery from trauma will be facilitated and sped up with our active approach, readiness and determination. You can start with elf-care, choosing what feels best for you. There are no formulas or prescriptions. Different strategies work for different people.

WHAT YOU CAN DO FOR YOURSELF

You can begin to do things on a personal level that assist the recovery process. For example, any effort you make toward eestablishing a sense of control over your life is very important. aking your own decisions whenever possible can be a basis for enhancing or restoring a sense of dignity, self-respect, pride and integrity. Even taking charge of the small decisions such as when to ake a walk or with whom you will share coffee is helpful for some people. Here is a list of different types of behavior that have helped other people in similar situraiton. They may help you too.

* Take care of your physical health.
  - Have a physical examination, if at all possible. If medical attention is not available, ask for it.
  - Trauma and ongoing stress can affect your physical health, whether or not you have visible injuries. Care for your health.

** Make an effort to establish daily habits.
  - Eat regularly as much as possible; reduce and/or control intake of alcohol.
  - Try to get enough rest, preferably on a regular schedule.
  - Engage in physical activity - it reduces stress.
    Exercise, play with children or just go for a walk regularly.
  - Establish some kind of daily routine, even if it differs from your usual one.

** Take care of your emotional needs.
  - Healing takes time and it varies from person to person. You are unique and so are individual traumatic reactions. Judging the length or nature of your traumatic reaction in comparison to others is not helpful. Allow your own time for recovery. Be patient with yourself.
  - Accept your feelings the way they are. Feeling rage, for example, does not mean you will hurt someone. Feeling out of control, for example, doesn't mean that you will lose control. Feeling helpless

doesn't mean that you are helpless. You may be discouraged or faltering but not helpless.

- Remember what has worked for you in the past in times of crisis or distress. Use those tools where they apply.
- Contacts with family, friends or people with whom you feel safe or close has been beneficial to other people who have been through traumatic experiences. Occasionally, you may feel you want to be alone, or you may want to be with others all the time, and that's okay. Follow your own instincts.
- Traumatic experiences can influence your sexual needs. Talk to your partner about what level of intimacy feels comfortable for both of you.
- Talking about the traumatic experience and your reponses to it can be important. It can help to share your experiences and what you learned from them with other people who have had similar experiences. It is not necessary to talk about all the deatils of your experience with others.
- Choose carefully who you talk with about your difficult experiences. There are people who can be of help when they listen to you and others who may make you feel more alone or more distraught. You may find that some poeple can hear everything while others can comfortably listen only to parts of your experience. Follow your instincts.
- Trained professionals can be very helpful to some people. Even one session with a skilled professional may be of assistance and may offer a frame for better understanding of your situation.
- Some situations, like anniversaries, significant dates in your life, or people may trigger painful memories. That can also be caused by media coverage or anything that reminds you of a traumatic event. Those situations will naturally occur in your life and it is

PANEL #8

impossible to avoid them. It would be useful to expect them and prepare for htem

- Finally, the most important thing you can do for yourself after experiencing trauma is to make a conscious effort towards taking care of yourself in the best possible way in all areas of your life.

After severe traumatic experiences, you may always remain cautious in some ways. Even so, many people who went thorugh similar experience manage to create meaningful lives after some time. Recovery takes time, but it can take place with adequate support.

* * *

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APPENDIX K

Presentation, "Educating Educators"

Special issues of Newly Arrived Refugee Groups

Theme: Bosnian Survivors by Amer Smajkic M.D., and Stevan Weane M.D.,

Specifically, my approach to this issue is discuss the processes which affect Bosnian refugees abilities to learn English as a second language. It is necessary to look beyond the simple act of learning itself and to see how learning English takes place within the context of key historical, cultural, social, Political, and psychological dynamics. It is my objective to share with you some of my thoughts on how these complexities impact the teaching of English expecially to recent Bosnian Refugees.

The specific unique elements of Bosnia and an independent nation go back since before the birth of Christopher Columbus.Bosnia was an independent country since the twelfth century with all factors that define a Country. We had our own Kings, flags, language, crypts, heros and folk songs specificly for Bosnia. Bosnians are Slavs.Bosnian Muslims are centuries old citizens of Europe.. The only difference between them and other Europeans is their religion. The cultural or social habits are European. History says that the first Muslims immigrated to Bosnia in the 10th century from Asia after wars there and through trade routes between the east and the west which passed through Bosnia. The Turkish "Ottoman" empire entered the Balkan area in 1371.

Bogumils had been the biggest percentage of Bosnian citizens and we can say the were the " native Bosnians" Islam was accepted by the Bogumils as a very compatable religion to their special brand of Christian religion. Muslims in Bosnia are not, as often stated, left over Turks from the ottoman empire. They are the peoples with a history which predates the Ottoman Empire. Their practices of culture are mainly European.

Later migrations that happened after war in Spain in 1492 between Queen Isabel and Spain's Muslims who were called Moors. The Moors had been in Spain since the 8th Century. They migrated from Granada to Bosnia and further defined the culture of the Bosnian Muslims. Spanish Jews also migrated to Bosnia at this time.

Most ,bu not all, of the Bosnians in Chicago are Muslims. the USA government gives priority to Bosnian Muslims because this group is the most threatened group in the Bosnian War.

Language Differences

Bosnian was a distinct Slavic language.

After the Second World War, the communist goverment defined the official language of Yugoslavia as Serbo-Croatian. Bosnian,Chroatian,Montenegrian and Serbian languages are basically the same languages,however, there are differences in pronunciation and idiom.

Bosnian is, however, separate and distinct from the commonly considered "Serbo-Croatian". For example *coffee* will be *kahva* in Bosnian *kafa* in Serbian and *kava* in Croatian. Also *softly* is *mehko* in Bosnian *meko* in Serbian and *mekano* in Croatian.

The English language has 26 symbols (letters) for 44 sounds or combinations, This makes English especially hard for pronouncing and using with transcription of each term.The sounds "w" and "th" present special problems.

The Bosnian alphabet has 30 symbols (letters) for 30 sounds it is functionally a phonetic alphabet. This challenge is emense for the aged and poorly educated Bosnians who try to learn English.

The Article which is so common in English, does not exist in Bosnian. In fact, I asked my friend to add the appropriate a's, the's, an's and so on to this text. In English nouns are not changed in number and gender or case with the exception of the Saxon genitive. In Bosnian nouns are changed in number, gender and seven cases. This, I understand makes Bosnian especially difficult for Americans with good educations to learn. In English adjectives are unchangeable, in Bosnian adjectives are changeable in number, gender and seven cases. English verbs present special problems . In Bosnian there are two auxillary verbs, "to be" and to "want". English verbs , including do, might, culd,should,would, are difficult.

Learning English

Most Bosnian people in Chicago go to Truman College.

There are seven levels and people may go during the day or night. We found that survivors who are highly motivated and those individuals who will add some extra effort will be more than successful in these and other colleges.

We also have volunteers that work under the umbrella of churches and refugee organizations.They work at refugees homes. Their success is open for discussion. This is not because they are not good teachers. It is only because their students are primarily wounded or other Bosnian groups which are handicapped by age, or other physical or mental problems.

Educational and intellectual differences are issues that make have significant impact on the process of learning English as second language. Clearly Bosnians with higher educational level are able to learn with less perplexity than those who are not highly educated. It is only a question of training and experience. People who are trained and experienced in learning, will do it more easily than those who are not.However , a number of other factors are involved.

Financial problems may complicate and confound the learning of English. Refugees are very limited with finance. They are not always able to get money for transportation, which means they will not be able to get to the school or college. For example, in Chicago we have excellent public transportation. If someone wants to go by train or bus he must spend 1.5 $ each way. Round trip would $3.00 .For a family with four members, two adults and two adolescents or children, the monthly income from Public Aid is around 420 $ plus food stamps.

A one bedroom apartment in Chicago costs from $380 to $500 minimum. One only needs to do basic math to understand that daily English classes would cost over $60.00 a month and there is no money left for rent, toothpaste or toilet paper.

Financial problem also bring more problems. Refugees without money try to find a job as early as it is possible. If they get something it will be a very low salary because they do not speak English. It will force them to do physical and hard jobs. Working eight hours or more a day, they are often very tired and find study difficult let alone sitting for three hours in a class.

The Bosnian population in Chicago varies in age from 1 to 90 years. Bosnian children and adolescents learn English much easier and faster than other ages.

Bosnians from 22 to 30 are also more than successful learning English.Bosnians over 30 are not as successful but many master the language with some difficulty. Many of this age group also give up and accept a future with limited language ability. People over 50 have serious problems learning English as second language. Most of them do not study English.

Genocide

I am certain you are familiar with those problems. In addition, what you must understand are the horrible experiences the Bosnian cannot leave behind them.

The mileau of learning is often emphasized as a major factor in education. The education of Bosnian refugees must include an understanding of the mileau which caused them to be in your classes.

The reason we are here today talking about Bosnians in America is that they were resettled after a forced relocation from their homes and cities in Bosnia as a result of the Serbian nationalist's initiative in "ethnic cleansing". Ethnic cleansing was the official Serbian policy to create a Greater Serbia that included the historical real estate of Bosnia but did not include the historic majority of the Bosnian population, the Bosnian Muslims.

The significance of the founding of the new Republic of Bosnia and Herzegovina was the concept that people of various religious and ethnic history could live together in harmony. Many orthodox Bosnians have ethnic roots in Serbia but choose to remain as Bosnians, not Serbs, Croats or Muslims. These persons are included in the cleansings. They and all those who opposed the Serb Ethnic Cleansing were considered disposable and, in many areas were forced to move or die. Serb forces attacked Bosnian civilians and used genocidal methodology including concentration camps, human atrocities, snipers, unopposed heavy weapon fire, and mass rapes to kill over 200,000 people and to terrorize another 1,000,000 into leaving their homes and relinquishing their participation in dream of a Bosnian multi-ethnic society.

The fact of Bosnians having endured genocide must be not be forgotten if one wants to understand their current dilemmas, especially those of learning English. Genocide attacks a person's cultural identity and their sense of participating in life.

Their efforts to build a new cultural identity as Americans or to achieve cultural and linguistic competency in America with English takes place in the wake of the severe trauma to their cultural identity which genocide.

Two thirds of Bosnia are completely "ethnically cleansed". In two thirds of Bosnia there are no any Muslims remaining alive.. In the rest of Bosnia we have cities such as Sarajevo or Gorazde and others that are surrounded by the serbs chetniks forces and isolated from the outer world. The civilians in these areas are the most threaten population, even today. They are surviving without elementary necessities. With out water, food, electricity, heat, and exposed almost every day to shrapnels and sniper's bullets. The genocide in Bosnia is, from the beginning of the war been directed against civilians irrespective of the region of Bosnia. In areas like Prijedor and its surrounding communities, serbian criminals organized the raping of Bosnian woman, they arrested every one who had a Muslim name and imprisoned them at Concentration Camps. In these camps they performed the worst barbaric crimes immaginaable. Many of these crimes are only recently being described to the rest of the world.

After the initial efforts of the Serbs, the Croatians also made an attempt to "grab land" using many of the same techniques. They were only a pale copy of the Serbs in their efforts to be barbarians.

Genocide is something which describes almost all important happenings in Bosnia. Genocide is something which affects our very souls and something with which we must always live. Genocide is an experience of Bosniacs and it is part of our past, present and future. One study found that the average Bosnian survivor was exposed to 17-en types of traumatic experiences.

Let me discribe what I mean by genocide. It is when your town is attacked by an army, when those who are attacked did not even think it was necessary to organize a defense let alone organize and arm an army. You must try to survive while, in front of you, people are dying: your parents or brothers or friends, or neighbors.

Your home is being destroyed, you are without of food, water or energy. After that they rape your sister or mother or you in front of those you most love and respect.

After exposure to traumatic events, survivors continue to experience considerable distress as a result of the trauma. The current psychiatric diagnosis that best addresses the psychological distress experienced by survivors is refereed to be PTSD. Posttraumatic Stress Disorder is the development of characteristic symptoms following exposure to an extreme traumatic stress involving direct personal experience of an event that involves death, injury, or a threat to the physical integrity: or witnessing an event that involves death, injury, or a threat to the physical integrity of another person: or learning about unexpected or violent death, serious harm, or threat of death or injury experienced by a family member or other close associate.

Symptoms of post-traumatic stress disorder may appear immediately after trauma or even months or years later. PTSD can be an acute, time limited, condition or it can become a chronic life long condition. We try to intervene as early as possible to prevent the development of chronic conditions similar to those documented in holocaust survivors, Cambodian refugees, and Vietnam veterans.

The symptoms of PTSD can be divided in to three groups.

Group 1

Rexperencining traumatic memories: recurrent and intrusive distressing recollections of the event, including images, thoughts, or perceptions. In young children repetitive play may occur in which themes or aspects of the trauma are expressed. Recurrent distressing dreams of the event. In children, they may be frightening dreams without recognizable content. Acting or feeling as if the traumatic event were recurring (includes sense of reliving the experience, illusions, hallucinations, and dissociative flashback episodes. For example a patient may say: “I am sitting in my apartment and I think and feel like I am in Bosnia and I am seeing everything which happened to me there” These are referred to commonly as “Flashbacks”

Group 2

Persistent avoidance of stimuli associated with the trauma and numbing of general responsiveness not present before the trauma:

Symptoms include:

-efforts to avoid thoughts, feelings, or conversations associated with the trauma.

-Efforts to avoid activities, places or people that arouse recollections of the trauma.

- Inability to recall an important aspect of the trauma.

- Markedly diminished interest or participation in significant activities.

- Feelings of detachment or estrangement from others.

-Restricted range of affect (like unable to have loving feelings).

- Sense of foreshortened future like does not aspect to have a carrier, marriage, children, or a normal life span.

Group 3

Persistent symptoms of increased arousal, not present before the trauma:

-difficulty falling or staying asleep, irritability or outbursts of anger, difficulty concentrating, hypervigilance, exaggerated startle response

Associated descriptive features and mental disorders. Individuals with Posttraumatic Stress Disorder may describe painful guilt feelings about surviving when others did not survive or about the things they had to do to survive. Phobic avoidance of situations or activities that resemble or symbolize the original trauma may interfere with interpersonal relationships and lead to marital conflicts, divorce, or loss of job. They may be increased risk of Panic disorder, Agoraphobia, Obsessive-Compulsive Disorder, Social Phobia, Specific Phobia, Major Depressive Disorder, Somatisation Disorder, Substance-Related Disorders, Insomnia.

Treatment for survivors of genocide is a complicated, multi-dimensional, and long-term prospect -- but it works. Survivors can get help from medications, from psychotherapy, from supportive relationships, and from work and other productive involvement's in their community. Symptoms of PTSD will come and go. They may be silent for decades and then return in the context of a new life stress or life change. At one point onetime a survivor may want to remain silent about their memories, and at anotherpoint onetime it may be very important for them to talk with another. Professionals working with survivors try to meet them where there at -- not to hurry them, or force them lest they risk retraumatizing the survivor. You who are not mental health professionals, but who are nonetheless, involved with survivors, must learn to appreciate the nuances of the survivor's mentality -- when they need silence and space, and when they need support and listening. Survivors will also look to you as an authority figure and try to sense how you feel about them and about mental health care. Here it is important to remember that most

Bosnians have no history of a good helping involvement with mental health professionals and the idea of PTSD is essentially foreign to them.

They often rely on folk concepts or terms such as "prolupao" that is a slang term for what you would say about your car when it is revving up but not going anywhere, or "puko" that is a slang term for something that is broken. You can do a real service for survivors by helping them to positively reframe what it means to have PTSD and to seek mental health services. As we say to them, you are having an expectable reaction to extreme circumstances. You are not crazy and its nothing to feel ashamed about.

How do these emotional and mental disturbances affect daily functions or especially learning English?

For example, I am studying for my medical boards and I have noticed that it's completely different to study now compared to before the war. I cannot memorize, study, concentrate, and focus like before. Survivors with PTSD can have serious problems in memorizing new data. For him or her is very difficult to adapt to anything what is new. It is very difficult to understand cultural shades. It is hard to learn how to deal with bills, medical system,public aid and other necesssary but complicated normal living activities.

How does one learn a new language? PTSD interferes with the normal cognitive processes of learning. Learning may be very hard if the patient is is reexperiencing trauma through nightmares or flashbacks, if the patient has intrusive thoughts, if the patient has numbing of responsivnes, if the patient avoids thoughts or acts related to his or her past trauma.

We may ask how many of Bosnian refugees have symptoms of PTSD.? I know I have some of them. I further believe almost every body who has experienced the trauma of Bosnia under the siege of Genocide would expectably have some sort of changes in his mental status. There is only question, how dominant are these symptoms? and will it affect somebody's ability to experience normal functioning.

We also must say that we can not make a model. We can not say that everybody responds in the same way to trauma. We have many internal defense mechanisms that are different from person to person. The effects of trauma will also depend on the age of the attacked person. It will depend on intellectual abilities and education, it will depend on the time of exposition and the etiology of the trauma.

Genocide, torture, and rape are a part of the experience of Bosnians. These criminal acts require special attention be given to the victims. Regarding this it is not only a sense of life threatening occurances. In situations such as torture or rape, patients may have serious problems with feelings of their honor, self confidence and trusting other people.

It is also important to consider how Bosnians think about their future. This genocide has struck at the very heart of the cultural identity of Bosnians. What will their cultural identity be? As multi-ethnic Bosnians? As Muslims? As Americans? Some would say that it's necessary to choose between being Bosnian and being American. I suggest that we think with the biculturalism model that says that one can achieve cultural competence in the ways of the host country, while maintaining the integrity of one's original cultural identity. We need to find ways to think about this that is not all or none. This is clearly going to be an issue that we are going to have to struggle with for a long time.

Contemplating the future for Bosnian people raises many more questions then it provides answers. The future of Bosnia and the possibility of whether Bosnian refugees in this country will be able return to Bosnian is very much uncertain. Some wish never to go back, while many would return the instant it were possible. This lingering uncertainty prevents the Bosnian refugee from committing to establishing a new life in America. It as if they were believing that to learn English and make a life in America was to acknowledge that which they refused to acknowledge -- that the Bosnia that they knew has been irrevocably changed by genocide.

And precisely because this genocide and war is still going on even as we speak here in this pleasant setting today, and the Bosnian refugee knows that their loved ones and family members are still there and in danger, their hearts and minds are to a large extent still in Bosnia. For many, they are just existing here. These are not the best conditions for learning English. But if it is your professional job to teach them English, you have no choice but to except these realities.

APPENDIX L

Crisis Intervention for the ESL Teacher: Whose Problem Is It?

By Cao Anh Quan
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Working with a student from another cultural background has been a challenge and a motivational factor for all ESL teachers. Working with multi-level refugee students is something most of us have learnt to thrive on. However, dealing with a crisis, especially one precipitated by a mental health issue is simply neither part of our training background, nor something that most of us would visualize being confronted within the space of the ESL classroom.

The statistics are there, lest we choose to ignore them. Rumbaut(1984) discovered that almost every one out of two refugees entering this country will face depression within their lifetime, this compared to the American mainstream ratio of one out of ten. Starr(1978) reviewed stressors faced by the refugee communities and find no comparable item for the general public on the mainstream scale:loss of country, loss of culture, loss of family member(s), loss of status, loss of way of life, all these losses compounded by the advent of culture shock thrust upon groups of people who are coming to the country of resettlement with very high expectations and minimal training and employment skills. A University of Hawaii study conducted by the School of Social Work revealed that the Vietnamese suicide rate in the state for the five-year period, 1978-1982, was 24.6 per 100,000, over twice the national average of 11.9 per 100,000 reported for 1980 in Morbidity and Mortality Weekly Reporter(5/21/85), this in a state with an extensive Asian community support system.

This article will review the stressors confronting the refugee student, focus on the role(s) the ESL teacher fills for his(her) students, and outline a series of guidelines for the teacher's usage in a crisis intervention situation.

Stressors in refugee resettlement

In the "Special Report: Physical and Health Care Needs of Indochinese Refugees"(1980), Court Robinson listed the problems identified by a national mental health task force in order of frequency: depression, anxiety reactions, marital conflict, intergenerational conflict, school adjustment problems, psychosomatic symptoms including fatigue, dizziness, weight loss, nausea, headaches, chest pain and insomnia. The frequency and severity of these problems have been repeatedly reported throughout the country in terms of rising incidences of health

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symptomatology with no organic basis, anecdotes of severe and unresolved grief reactions, post-traumatic delayed stress and high rates of family conflict and break-up.

First and foremost amongst the stressors the refugees encounter is the flight process itself. For almost all refugees it is a long, arduous, dangerous, complex and frequently hazardous process. The United Nations Higher Commissioner for Refugees, working through the assistance of host governments and donor countries, is mainly responsible for the welfare of these groups from the flight from their homeland and subsequent arrival to holding camps to their eventual assignment to a country of resettlement. Once in the country of resettlement, the process is even further impacted by culture shock and displacement. Just the overflow of new information and resources can become another source of confusion, difficulty and trauma. Improved federal policy and local input into the service delivery process have minimized the isolation process which once was prevalent with the policy of dispersion. However, the stress on "employment first" have exerted additional pressure on local and state systems, which are continually experiencing frustration in finding employment for their own indigenous clients. In a mental health needs assessment conducted with service providers in eight Southeastern U.S. states, respondents indicated that "mental health" problems, per se, did not surface however during this initial period of arrival. Rather, in a Maslowian hierarchical structure, psychosomatic symptoms, depression and other indicators of stress are exhibited in the context of the emergency room most often after the first year, when basic needs such as finding suitable housing, putting children into school, securing the first job have already been met and things are expected to get better. These developmental and situational crises seem to crop up again around permanent residence status application and then naturalization application times.

Table I: Acculturation Timeline

```
  6 mths        1-2 yrs.          3 yrs.          2-3 yrs
x-----------xx-------------xxx------------xxxx-----------xxxxx-----

FlightEncampmentPrimary         Permanent            Citizenship
                Resettlement      Residence
```

A significant amount of secondary migration has occured after the primary resettlement for a number of different reasons: reunification with extended family members and friends, dissatisfaction with climate or community, lack of employment, breakdown of sponsor relationship and ensuing loss of face with ethnic community. Secondary migration usually resulted in continuing "problem" resettlement, because the "problems" have simply been transferred to a different geographic location. As a rule, they tend to occur in inner city neighborhoods with low cost rental housing, availability of low level employment, and proximity to members of the same ethnic community.

Rumbaut pointed out that the 6 month - 1 year after initial resettlement period is typically a period of toil and physical hardship as well as one of discovery and new learning. The mood of the newcomer during this phase is one of elation and joy. Subsequently however, depression sets in after the first basic needs are met. He went on to ascertain that although most refugees manage to cope with the ensuing depression and difficulties, very few will return to the elation period of those first six months. Researchers, keying on the different S.E. Asian refugee waves in terms of their ethnic origin, socioeconomic status, degree of urbanization, prior education and employment, have hypothesized that depression coincides for the 1975 group with their citizenship and the graduation of their children from high school, approximately 7 to 9 years after their arrival. For the subsequent waves, the time frame is much shorter, anywhere from 3 to 5 years, due to the increasing hardship of their flight experience coupled with rising expectations concerning family reunification and life in the U.S.

Who do refugees go to when they need help? Cross-cultural factors play a key role in the expectations of the person seeking help and the perceived helper. Table II looks at the three different modalities of intervention through time. It has become increasingly clear that in the spiritual and the bio-chemical modalities, the emphasis is placed on the ability of the helper, be that person a physician or an elder member of the extended family system, to provide immediate solution and guidance. In the psycho-social modality, the focus is on the ability of the individual to "do for self" through ventilation and verbalization.

This is further exacerbated for both helper and client when one considers the language and culture barriers that both sides have to overcome to arrive at an accurate diagnosis and an effective treatment plan. Service providers have told us repeatedly that working through a translator is not the ideal situation, especially if the translator is untrained. It is essential for us to note here that the bilingual paraprofessional, serving as translator, plays a dual role. For the client and the community, this person explains linguistically and culturally "how" things

Table 11: Modalities of Intervention

Mode	Helper	Expectation
1. Spiritual	Extended Family Clergy, Monks Shaman, Soul Callers	Advice Solutions
2. Physical (Bio-chemical)	Herbalist Physician Nurse	Diagnosis/Treatment Medication Injection
3. Psycho-social	Psychologist Counselor Social worker	Ventilation Feelings Self-concept

get done. For the agency, he/she has to explain "what" the perceived problem is. This same person is an "American" for his/her ethnic group and a "refugee" for the mainstream. It is a position of risk and compromise for which few people either has the training or the ability to fulfill.

The Role of the Teacher

When we asked translators to literally define "mental health" in their language, they cannot come up with a term for it. A Mental Health Center becomes a "crazy hospital". Depression becomes "extreme sadness" or "sickness of the nerves", or of "the heart", or of "the liver" depending on the ethnicity of the translator. Labeling the problem alienates the refugee client further from any support system they may have had. This is another reason why a refugee may sometime appear quite resistant to talk to someone from their own ethnic group about their problem for fear of ostracism and rejection from the group.

In their country of origin, the teacher has always played a key role. The teacher controls the gates of knowledge in a structure where literacy is more the exception than the rule. In the old mandarin structure, and to a great extent, under colonialist rule, the teacher is always at the top of the caste system (Si, Nong, Cong, Thuong: Teacher, Farmer, Laborer, Trader). Their initial experience with the new society reinforces that belief: when you have a problem, the ESL teacher can frequently help you or show you how to get the problem taken care of. Teachers have identified for us the numerous roles they take on within their instructional capacity: cultural translator, surrogate parent, driver, appointment keeper, "father confessor", advocate, counselor, friend, mediator, explainer of rules and explainer of "how to get around rules".

Guidelines for Crisis Intervention

When the "gift" of a problem is offered to the helper, it is crucial to us as a helper to assess the severity of the problem at hand. If the expectation is for us to solve the problem, solving it may help meet the refugee's expectations, but it may also create a dependency pattern. If the situation is one involving danger for the client to self and others, we may not have the choice but to step in and take an appropriate course of action. Following are seven procedural steps outlining a crisis intervention:

1. Pre-planning
2. Physical support
3. Assessment
4. Resources utilized to date
   Treatment plan
5. Referral
6. Follow-up
7. Closure

In addition to these crisis intervention steps, there are also some cross-cultural treatment considerations we have found very useful in our clinical setting. These would fit well into the kinds of background cross-cultural information and student data teachers usually look for in the context of a classroom:

1. What are the issues? problems? people involved?
2. Would this have been a problem in culture of origin? Or is it a result of the experience of flight? or of culture shock?
3. If this had been a problem in culture of origin, who would have been the natural helpers? Are they available here? Ensuing expectations? Outcomes?
4. What resources have been utilized to date? Natural consequences of situation? of intervention?
5. What course of action could you take that would most likely create a Worse Outcome?

Finally, these are some cultural tips dealing with non-verbal behavior, attitudes, values and behaviors that have proven helpful to teachers, counselors and professionals we have worked with. We have separated them into "passive" and "active" strategies, not that the active strategies require any more "doing" than the passive ones, but that in terms of timing, you may choose as a teacher to start with a new student with the passive steps first before moving on to the active, which come later within the change process and as students become more familiar and comfortable with the new culture's "direct" communication,confrontation style:

PASSIVE	ACTIVE
1. Observe patterns of interaction (work, play, lunchroom,etc...)	1. Encourage these, even if they do not conform to mainstream behavior
2. Watch non-verbal behavior in different contexts (within same ethnic group, with other LEP students, with American friends)	2. Show "American" characteristics through role modeling
3. Pay attention to any sudden change of behavior (social interaction, appetite, work, etc...)	3. Encourage new roles ("gradual adaptation")
	4. Seek parent participation and reaction to school activities/functions
	5. Encourage all students in their interest/interaction with each other´s cultural background.

In the final outcome, the challenge of working with the refugee student is frequently its very own reward. Students come back to visit year after year, and talk continuously about the difference that the ESL teacher has made in their acculturation to this new country and the trust and support that they provided. That is the best definition of "mental health" service delivery that we can think of, which is provided without any labeling involved. In the age of the Global Village, we can only point to the central and pivotal role of the ESL classroom teacher in providing not only language and culture, but a sense of hope and faith in the human ability to learn and grow.

Annaheim, California
March 1986

Stressors in the refugee resettlement process

Within the family system

Role changes: adult - child
male - female
elderly

Values, attitudes & behaviors: extended vs. nuclear
close vs. open
group vs. self
cooperative vs. competitive

With the old culture: focus on the past

Survivor's guilt & post-traumatic delayed stress

Self-identity & marginality

Generation gap

Within the mainstream society: focus on the present

The institution of the school

Work

Language barriers

Cultural barriers (time, communication patterns, interpersonal relationships)

Aspirations: focus on the future

Education

Careers

Family

Special considerations: High Risk Groups

Single male adolescents - UMR's

Single parents(homebound women with children)

Amerasians

Ex-military

Clergy

Elderly

APPENDIX M

DOCUMENT RESUME

ED 204 471

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TITLE	Can TESOL Teachers Address the Mental Health Concerns of the Indochinese Refugees? Draft.
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ABSTRACT

This paper examines research in the fields of psychology, anthropology, and the Teaching of English to Speakers of Other Languages (TESOL) as it relates to the mental health needs of the Indochinese refugees. It is argued that TESOL instructors are in a key position to influence the adaptation process of refugees in their classes. Cultural values of the Indochinese are explored, and methods that TESOL instructors might use to facilitate acculturation and improve mental health are outlined. Teachers are urged to remain aware and responsive to changes in their students' behavior. (APM)

*** NOTE: Portions of this paper discuss government funding for special mental health projects for refugees and the use of TESOL classes in these efforts.

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the numerous human problems associates with acculturation and to research and revise these alternatives as they are proven inefficient or as they become obsolete. Hopefully, these efforts will be carried out sensitively and with respect for other cultures.

A final comment about TESOL and refugees' mental health related to the level of secondary prevention of mental illness which involves early detection and treatment of problems. Most teachers don't have formal training in evaluation and diagnosis of mental disorders. Because teachers are in daily contact with their students, changes in students' demeanor or behavior become important cues. Teachers need particular awareness of these changes with their Indochinese students because the value placed on repression and denial of affect contribute to making overt symptoms more subtle. Experience with other refugee and minority groups indicates that frequent complaints about headaches or other physical symptoms sometimes suggest a psychologically based problem. The teacher must be cautious not to put a student in an embarrassing situation by calling this to the student's attention in front of others. If there are doubts about the existence of a problem, calling in a consultant is adviseable. If this service is not available, a private conversation with the student should be offered. Any referral ought to be done on a personal basis with a formal introductory meeting convened by the referring TESOL teacher. Tertiary prevention of mental illness is the elimination or reduction (i.e., treatment) of existing problems. As with secondary prevention, most teachers are not equipped with training to address this area of concern, particularly in a culturally appropriate manner. Many persons in the United States have come to view psychotherapy as a cure for various problems but there is little agreement on what psychotherapy involves or on its efficacy in helping people. Brown (1975) notes that current definitions of the term mental health are so ambiguous that they describe "a human ecology that encompasses at least the earth, if not the universe . . ." (p. 2324). Rather than impose this ambiguity on refugees whose needs for structure and stability are more like those of a newborn child (Weinberg, 1955), it would be better to call English instruction what it is and not confuse the task. The effect of English instruction on assimilation, adaptation, and acculturation will occur regardless, and by clearly delineating its aims it will be more acceptable to the Indochinese.

APPENDIX N

CANADIAN CENTRE FOR VICTIMS OF TORTURE

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Issue September 1994 #9

An Overview: ESL for Survivors

In considering the settlement process for newcomers to Canada who have suffered torture, arguably the most daunting challenge is learning English. It is a goal that is at once the most illusive and difficult to attain, yet the single most important tool required by any newcomer. Fluency in the language of the society one settles in allows for more freedom and control over one's life. Without language, the simplest of tasks such as making a telephone call or asking for directions pose insurmountable barriers.

There are considerable differences in how individuals progress in second language acquisition. While some learners manage to achieve complete bilingualism, others never advance beyond a low level of proficiency. Linguistic research suggests that there is a significant number of factors which impact the learning of a second language, including age, aptitude, personality, and cognitive style. Social-psychological factors such as self esteem, attitudes towards the new society and its language, and the psychological well-being of the learner also come into play.

Survivors of torture typically suffer what the American Psychiatric Association has identified as Post Traumatic Stress Disorder (PTSD), whose main cause is "a psychologically traumatic event that is outside the range of usual human experience."1 Symptoms of PTSD that both directly and indirectly affect the learning of a second language are: memory impairments, depression, loss of self esteem, disruption of normal sleep patterns, recurrent nightmares, a re-experiencing of traumatic events and an inability to trust other individuals, particularly those holding positions of authority. Overcoming these obstacles as best as possible must be a priority in any English language instruction programme for survivors.

The ESL programme at the Canadian Centre for Victims of Torture (CCVT) has attempted to meet the needs of victims of torture in the classroom through several strategies. Most notable is the integrative approach. All classes are held on site at the CCVT with intake counsellors present. In this way a support system for both students and instructors is established. If a student experiences a crisis while in class (i.e. a flashback of a traumatic event, or a more mild form of trauma such as depression), seasoned counsellors with background in the client's history can step in. Counsellors can also provide advice to instructors regarding specific students' behaviour in the classroom.

Within the ESL programme the mandate is as much about rebuilding self-esteem in the learner as it is about language instruction. A positive self-image is an indispensable ingredient for carrying out almost any cognitive activity. For second language acquisition, it is crucial. The learner must always be prepared to take risks with the new language, knowing s/he will inevitably make mistakes, particularly in the early stages of instruction. This can be difficult for survivors, since torture by its very nature is an implicit attack on the personality and self-image of the individual.

A good beginning in helping survivors feel more confident about learning English is to make the classroom situation as informal and comfortable as possible. Students are not prohibited from coming and going within the period of instruction if they feel they need a break. Learning activities are of a non-academic nature and food is often shared during class hours.

Once students establish themselves in the class after an initial period of adjustment, noticeable differences are often observed. Even the most reserved students begin to form relationships with others and participate in classroom activities. Attendance tends to be quite good (75 to 80 per cent class averages), with many students remaining after class hours to socialize and take advantage of other services offered by the CCVT.

It has also been our experience that the comfort level of students is higher when class size is small. A ratio of 10 to 12 students to every instructor works well. When this is not possible, volunteers — an indispensable asset to the ESL programme — work with students in small groups that help to break up a large class and/or work with learners who require special attention.

An important means of establishing confidence in students is to use the ESL classroom as a bridge into the community. Frequent class outings is one way to accomplish this. These trips can be of an academic nature, such as visiting a museum, but more often they should attempt to familiarize students with their new community. Examples include going to the post office to purchase stamps, shopping for cookies for break time, or going to a cafe for conversation.

The ideas outlined above represent only a small portion of what can be done in an ESL class for torture survivors. The guiding principle for the ESL instructor must always be that individuals have survived torture, to some extent, at the expense of her/his self esteem. Making the ESL classroom a place where learners can feel positive about themselves is a big step down the road to second language acquisition, as well as personal well-being.

Lorena Bekar
ESL Programme Coordinator

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1. Report of the Canadian Task Force on Mental Health Issues Affecting Immigrants and Refugees, *After the Door has been Opened* (Ottawa, 1988) 85.

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APPENDIX O

A. THE ROLE OF THE ESL TEACHER IN PRIMARY PREVENTION

The teacher in the ESL classroom plays a crucial part in the promotion of mental health, the enhancement of coping skills, and the social well-being of refugees. To begin with, the ESL teacher has a very special and unique relationship with the refugee student. Southeast Asians, for example, place great value on education, with the teacher in a highly respected position. In fact, according to tradition, questioning the authority of a teacher is not something a Southeast Asian adult would consider. The ESL teacher may also be the one American with whom the refugee student has regular and extensive contact.

As the teacher-student relationship develops, and along with it, an increasing amount of trust, it naturally follows that the teacher who listens will begin to hear, directly or indirectly, about stressful social, environmental, and institutional demands. During a teaching activity on housing, for example, a student might mention that there has been no heat in his her apartment for over a week. Or, a student might apologize for having missed class because of fear of traveling alone on the subway, or fear of being robbed on the neighborhood streets.

It is probable that the ESL teacher is not the only "helper" aware of such problems. It is also likely that the students have attempted to resolve problems with the help of their own support networks. The ESL teacher does, however, become part of this help-seeking system, and will be most effective in the area of primary prevention in the classroom by assuming the role of:

- **A good listener,** allowing students to express and vent feelings and share prior experiences with each other;
- **A mediator between cultures,** helping students to understand the meanings behind social, environmental, and institutional demands;
- **A provider of information** who will prepare students for possible future stressful events and direct students to community resources for help;
- **A facilitator,** allowing for a classroom conducive to sharing, problem-solving, and the rehearsal of coping skills;
- **A model or representative of a culture,** allowing students to observe cultural differences, and to draw conclusions about these differences.

Before adopting teaching strategies shaped around these general principles of primary prevention in the classroom, teachers and or program administrators need to examine the context in which an ESL program functions, to determine scope and feasibility in the curriculum. The following elements should be considered:

1. ESL Teacher's Strength and Limitations

The primary task of ESL instructors is to teach English. Assuming a role in primary prevention involves considering the social, psychological, and language needs of the refugee student together. As ESL teachers become more conscious of the stress-producing demands on their refugee students, however, teachers cannot allow their roles to expand in such a way that they assume responsibility for functions not appropriate for their position. For example, taking on the responsibility to directly resolve a refugee's home heating problem or a neighborhood crime situation is probably not within the job description or the expertise of a teacher. In fact, involvement at an individual client level, if not appropriately done, could complicate matters, duplicate other efforts, and in other ways be counterproductive.

Teachers assuming roles in primary prevention should:

- Understand that they have no control over the emotional pain a refugee experiences nor over what a refugee faces;
- Recognize they are part of a network of "helpers" who are working toward similar goals;
- Advocate for further training and staff development, especially if responsibilities other than teaching are expected to be carried out;
- Advocate for adequate support for both teachers and students;
- Avoid "burn-out" by joining local professional organizations, taking time off, and sharing frustrations with peers;
- Establish realistic goals, recognizing their own strengths, skills, and limitations.

2. Refugee Students' Expectations: Stressful Life Situations

A refugee student in the process of social adaptation is coping with the loss and trauma of forced migration and facing the innumerable stressors created by new social and environmental demands. It is not surprising that refugees look to the ESL class as a place that can facilitate this process. For an ESL class to do this effectively, it is essential that programs and individual teachers assess the needs of students as a group. (See Chapter B, Section II).

3. The Classroom

A classroom that is most conducive to the promotion of mental health and enhancement of coping skills is one that:

- Has a low anxiety level;
- Fosters feelings of belongingness and success;
- Is receptive to student issues and cultural traditions;
- Is responsive to the learning styles of individuals in a class;
- Reduces isolation by encouraging peer support and sharing of experiences, feelings, and opinions;
- Recognizes that the prior knowledge and experiences of refugee students can serve as a bridge to new learning;
- Encourages students to participate actively and to assume responsibility;
- Provides maximum opportunity for rehearsal;
- Brings the real world into the classroom.

4 Curriculum Materials Teaching Approach

Curriculum, materials, and teaching approaches will vary widely, depending on a particular program's goals, level of students, availability of teaching and community resources, and the teaching style of each teacher. When examining these areas in relation to primary prevention, adaptation of existing materials and methods may be required. In the adaptation process a teacher should ask him/herself the following questions:

- How do I help to change self-defeating attitudes of refugee students to positive ones?
- Do I use strategies that help students to gain confidence, both in and out of the classroom?
- Does my teaching enable students to feel successful with their language learning?
- To what extent do the materials and curriculum mirror the reality of the refugee's world?
    - Do they draw on prior knowledge and experience?
    - Do they take into consideration the cultural and socio-economic conditions of the refugee?
- Do the materials and curriculum focus on students' day-to-day needs as well as emotional needs?
- How do I combine ESL subject areas (e.g., transportation) with students' emotions, feelings, and anxieties (e.g., fear of taking the subway)?
- Do I allow for cultural differences to be examined in the classroom?
- How do I promote critical thinking, inquiry, and the gaining of information?
- Are students asked to develop their own strategies for addressing stressors?
- Do I teach language that will enable students to take more control of their lives? Language that goes beyond identifying and accepting?
- Are community resources a regular part of classroom activities?
- How do I ensure that rehearsal opportunities occur regularly?
- Do I use activities that allow students to apply newly-learned coping skills in real-life situations?

5 Local Community Agency Relationships

ESL programs should be reviewed in relation to their own local communities, their support networks, and the resources refugees access or could access. This can be viewed at two levels. First, there are refugee-specific support systems and networks with which the student is familiar, such as sponsors, temples, Mutual Assistance Associations (MAAs), and role models within the ethnic group (it is this network with which ESL teachers may be less familiar). (See this Handbook, Chapter C, Section II.) Second, there is the existing host community and its social structures with which the refugee may still lack basic familiarity, understanding, and information. These could be resource people such as housing advocates, lawyers, police, job developers, employers, local government officials, or day care workers.

Coordination with and inclusion of information about social service systems and other community support networks has to be part of ESL curriculum and staff development activities. This is essential because the adult refugee student needs to learn to interact with host institutions and to use new taxonomies that categorize the world differently. This is an educational process that leads to accessing "mainstream" services. Using and drawing on information about community resources in the classroom is one way for refugee students to develop strategies for coping and self-help. ESL teachers should view themselves and strive to be viewed by others as part of the larger community of helpers. This should increase the likelihood of success for their primary prevention efforts by linking them to a larger community of people and activities. Finally, ESL teachers must view themselves as agents of change, playing a vital role in sanctioning use of help-givers by refugees.